

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13684

CERTIFICATE OF DEATH

13688

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 10yr9mo 14 days Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 843 N. Eutaw Street	
3. NAME OF DECEASED (Type or print) Anthony Baglione		4. DATE OF DEATH Month 10 Day 15 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-15-09
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT U.S.A. COUNTRY? naturalized	
13. FATHER'S NAME Joseph Baglione		14. MOTHER'S MAIDEN NAME Bessie Tomeo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 213-09-1535	
17. INFORMANT Address Sykesville, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyelonephritis and suppurative nephritis DUE TO 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral bronchopneumonia DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic Depressive reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-16- 19 56 , to 10-15- 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-15- 19 67 , and that death occurred at 10:05 AM from causes and on the date stated above.			
22a. SIGNATURE Suha Ozgun		22b. DATE SIGNED 10-16-67	
22c. PHYSICIAN'S NAME (Type) Suha Ozgun, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-18-67	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION (City or Town) (County) (State) 7401 Gorman Hill Rd., Md.
24. FUNERAL DIRECTOR Charles S. Geiler		25a. REC'D BY REGISTRAR OCT 20 1967	
ADDRESS 6224 Eastern Ave. Balto., 21224, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 1y. 24days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		d. STREET ADDRESS Box 57	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Barthel		4. DATE OF DEATH Month 10 Day 8 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/91
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) social work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Woods		14. MOTHER'S MAIDEN NAME Debra K. Bridget Gartland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 055-24-3888	
17. INFORMANT Address Springfield Hospital records, Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome with senile brain disease with psychotic reaction			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/14/ 1966 , to 10/8/ 1967 , that <input checked="" type="checkbox"/> (we) lost the deceased on 10/8/ 1967 , and that death occurred at 9:45 a.m. from causes and on the date stated above.			
22a. SIGNATURE Carlos G. Levin, M.D.		22b. DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) Carlos G. Levin, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/67	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	23d. LOCATION (City or Town) (County) (State) Middle Village, N. Y.
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701		25a. REC'D BY REGISTRAR ACT 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

M. A. Richmond & Son, Frederick, Md. 21701

St. John's Cemetery

Medic Village, N. Y.

[Handwritten signature]
James A. Smith, Jr., D.D.

Springfield State Hospital
Springfield, Mass.
Nov 21 1951

Enclosed is the report of the committee on the subject of the

no 100-1-10000 Springfield Hospital records, Springfield, Mass.

John Smith

social work

New York

James A. Smith, Jr.

12/21/51

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James A. Smith, Jr.

Springfield

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Springfield State Hospital

Nov 21

James A. Smith, Jr.

Springfield Hospital

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Frederick

13686

CERTIFICATE OF DEATH

13690

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 11 yr. 2 mo. 6 da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL		d. STREET ADDRESS 713 Maryland Avenue	
3. NAME OF DECEASED (Type or print) First DONATO Middle NMN Last BASILE		4. DATE OF DEATH Month 10 Day 16 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1884
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months 10 Days 16 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Foreman		10b. KIND OF BUSINESS OR INDUSTRY cement mfg.	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? 1st papers	
13. FATHER'S NAME Stephen Basile		14. MOTHER'S MAIDEN NAME Marie F.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding gastric ulcer 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH weeks days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) reaction CBS assoc. with circulatory distb. with cerebral art. with psychotic		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/10/56 , 19__, to 10/16/67 , 19__, that (I) (we) last saw the deceased alive on 10/16/67 , 19__, and that death occurred at __ M, from causes and on the date stated above			
22a. SIGNATURE <i>Isaac E. Hapner</i>		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) Isaac E. Hapner, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-19-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR <i>Frank L. Mimmich</i>		25a. REC'D BY REGISTRAR PCT 20 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13587

13691

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 1 yr 11 mo 11 da	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 17 W. Main Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle GORDON Last BEEMAN		4. DATE OF DEATH Month 10 Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/22/12
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY STATE ROADS	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Beeman	
14. MOTHER'S MAIDEN NAME Laura Jane Horton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 213-10-9859		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent bronchopneumonia 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis with behavioral reaction			INTERVAL BETWEEN ONSET AND DEATH Days Years
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 'a.m. 'p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 11/12/ 19 65 to 10/26/ 19 67 , that (I) (we) lost saw the deceased alive on 10/26 19 67 , and that death occurred at 8:15 PM , from causes and on the date stated above.	
22a. SIGNATURE Alfredo M. Labrit, M. D.		22b. DATE SIGNED 10/26/67	
22c. PHYSICIAN'S NAME (Type) Alfredo M. Labrit, M. D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF OCT. 29, 1967	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG MARYLAND
24a. FUNERAL DIRECTOR MAILED M. SOBERS HAFER SOBERS FUNERAL HOME		24b. RECD BY REGISTRAR OCT 31 1967	
24c. ADDRESS 60 W. MAIN, FROSTBURG		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13688

CERTIFICATE OF DEATH

13688

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Westminster</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Carroll County General Hospt.</i>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i> d. STREET ADDRESS <i>11137 Reisterstown Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Edith</i> Middle <i>E.</i> Last <i>Bosley</i>			4. DATE OF DEATH Month <i>10</i> Day <i>14</i> Year <i>1967</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Dec. 23, 1900</i> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i>03</i> Days <i>2</i>		IF UNDER 24 HRS. Hours <i>03</i> Min. <i>2</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Employed at Landray</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Balto. Co. Md.</i>	
13. FATHER'S NAME <i>Noah A. Bosley</i>		14. MOTHER'S MAIDEN NAME <i>Violet Harris</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-05-1686</i>		17. INFORMANT <i>Mrs. Lillian G. Baublitz</i> Address <i>Owings Mills, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> (c) <i>DIABETES MELLITUS</i> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/14</i> <i>1967</i> to <i>10/14</i> <i>1967</i> that (I) (we) last saw the deceased alive on <i>10/14</i> <i>1967</i> and that death occurred at <i>6:30</i> P.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>Vincent J. Knoch Jr.</i> M.D.			22b. DATE SIGNED <i>10/14/67</i>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 17, 67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wesley Cemetery</i>	
23d. LOCATION (City, town or county) <i>Carroll Co. Md.</i>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Eline & Sons</i>			ADDRESS <i>Reisterstown, Md.</i>		
25a. RECEIVED BY REGISTRAR <i>Oct 17 1967</i>			25b. REGISTRAR'S SIGNATURE <i>J. F. Eline</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13689

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2025 N. Bentalou St. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Mary Middle T. Last Boyd				4. DATE OF DEATH Month October Day 31 Year 1967											
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-22-02		9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS: Hours 0 Min. 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (County & State, or foreign country) Virginia (Millwood)		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Taylor, dec.						14. MOTHER'S MAIDEN NAME Rebecca									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 215-22-0212-A		17. INFORMANT Hospital Records		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Bronchopneumonia DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH years days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral old sub-dural hematomas								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-24</u>, 19<u>67</u>, to _____, 19____, that (I) (we) last saw the deceased alive on <u>October 31</u> 19<u>67</u>, and that death occurred at <u>7:10 PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <i>Sergio J. Palacio</i>								22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) Sergio J. Palacio, M.D., Attending Physician								22d. ADDRESS Springfield State Hospital, Sykesville,							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/3/67		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park				23d. LOCATION (City, town or county) (State) Arbutus Balto Co, Md					
24. FUNERAL DIRECTOR Herbert E. Nutter								25a. RECEIVED BY REGISTRAR NOV 3 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jager</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13690

CERTIFICATE OF DEATH

13694

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 1 yr. 1 da	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL		d. STREET ADDRESS 143 W. Patrick Street	
3. NAME OF DECEASED (Type or print) First BERNARD Middle BELL Last BROOKS		4. DATE OF DEATH Month 10 Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-96 08/22/96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deliveryman		10b. KIND OF BUSINESS OR INDUSTRY Dairy	9. AGE (In years last birthday) 71 yrs
11. BIRTHPLACE (County & State or foreign country) Maryland Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Brooks		14. MOTHER'S MAIDEN NAME Mildred Bell Emma Bell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1916-19		16. SOCIAL SECURITY NO 217-10-0192	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho-pneumoniz - left lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with old DUE TO (c) myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH days
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis with psychotic reaction			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from 08/22 , 19 96 , to 10/29 , 19 67 , that (I) (we) last saw the deceased alive on 10/29 , 19 67 , and that death occurred at 9:20A , from causes and on the date stated above			
22a. SIGNATURE <i>Rafi Q. Iqbal</i>		22b. DATE SIGNED 10/29/67	
22c. PHYSICIAN'S NAME (Type) Rafi Q. Iqbal, M. D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov. 1-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR N.R. Etchison & Son - T.		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Whitmore Frederick, Md. 21701		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 31 1967			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13695

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Airy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Airy	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R. D. 4		d. STREET ADDRESS R. D. 4	
3 NAME OF DECEASED (Type or print) First CHARLES Middle T. Last B USSARD		4. DATE OF DEATH Month 10 - Day 16 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 15, 1870
9 AGE (In years past birthday) 97 yrs		10 IF UNDER 1 YEAR Months 10 Days 16 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY Howard Co., Md.	
11 BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Randolph Bussard		14 MOTHER'S MAIDEN NAME Mary A. Kaire	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 220-54-7719	
17 INFORMANT Mrs. Mary Brothers R.D. Mt. Airy, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arterio Sclerotic Cardio DUE TO (c) Vascular Disease Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Several yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day, Year Hour 0 m 19 p.m.		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. Glenn Speicher		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) 135 E. Main St.		22. DATE SIGNED 10-16-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/1967	
23c. NAME OF CEMETERY OR CREMATORY Bethesda Cemetery		23d. LOCATION (City or town) (County) (State) Bethesda, Carroll	
24. FUNERAL DIRECTOR C. M. Waltz		ADDRESS Box 241 Sykesville, Md.	
25a. REC'D BY REGISTRAR OCT 19 1967		25b. REGISTRAR'S SIGNATURE R. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13693

CERTIFICATE OF DEATH

13697

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 7mos. 21dys.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 1935 Pennsylvania Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NAOMI Middle (NMN) Last CARROLL				4. DATE OF DEATH Month OCTOBER Day 4 Year 1967			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-20-1894	
9. AGE (In years birthday) yrs. 73		IF UNDER 1 YEAR Months 7 Days 19		IF UNDER 24 HRS. Hours 19 Min 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jasper Whitney				14. MOTHER'S MAIDEN NAME Sally (last name unk.)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 218-30-7302		17. INFORMANT Address Records, Springfield State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary arteriosclerosis DUE TO (c) Severely infected multiple decubitus ulcers							INTERVAL BETWEEN ONSET AND DEATH Years Years Weeks or Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-13-67 , 19 10-4-67 , 19 10-4-67 , that (I) (we) last saw the deceased alive on 10-4-67 , 19 10-4-67 , and that death occurred at 12:30 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Dr. Antonius Glahn</i> M.D.				22b. DATE SIGNED 10-4-67		22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.	
22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-7-67		23c. NAME OF CEMETERY OR CREMATORY Arbutus Cem. Pk.		23d. LOCATION (City or Town) (County) (State) Arbutus Maryland	
24. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

13694 Items #8 & 9 & 10a Film #3 23 16/12/57 ph

13694

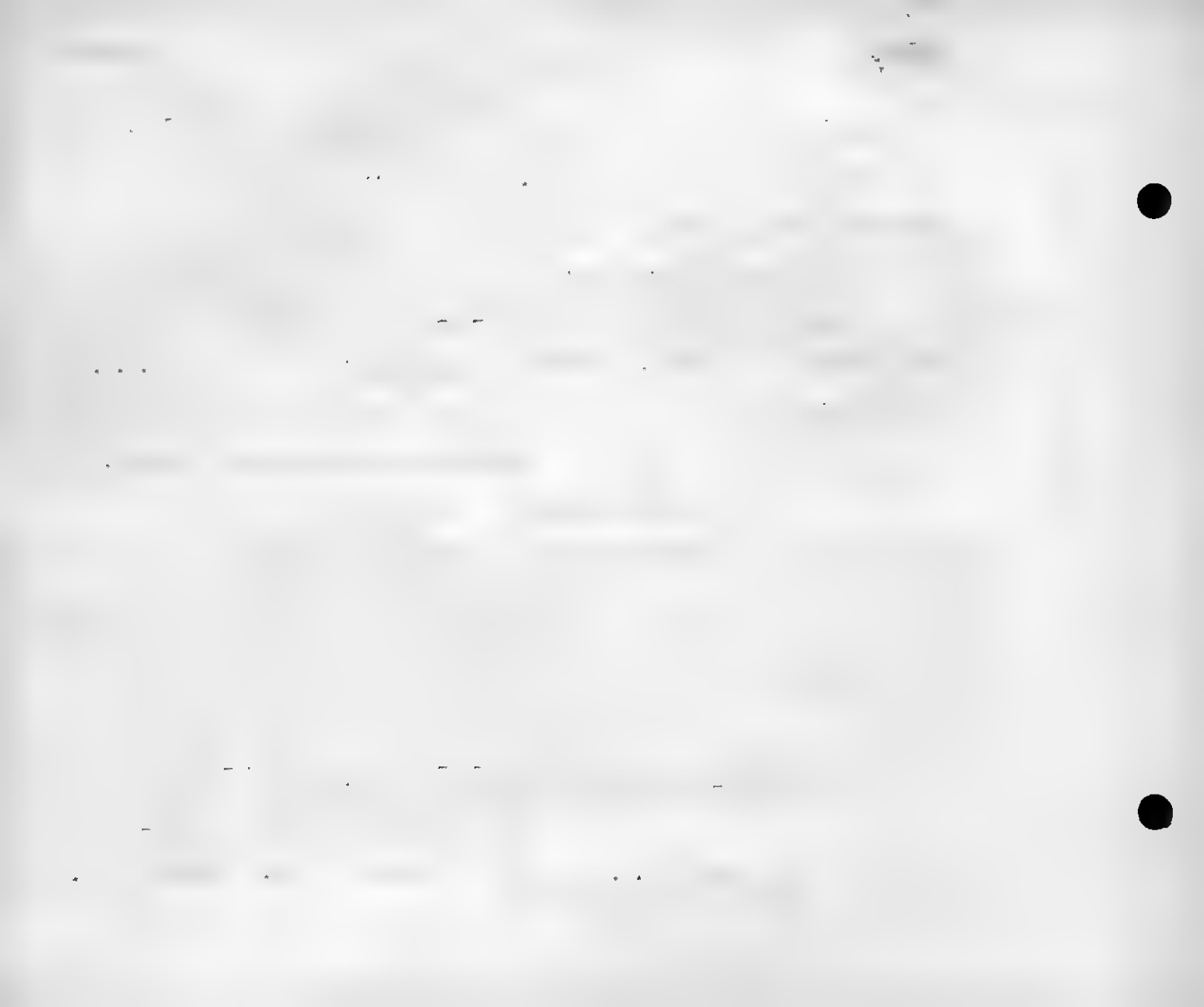
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 24yrs. 4mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Henry Chronister		4. DATE OF DEATH Month October Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-83/ 1882
9. AGE (In years last birthday) 84 1/2 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman Handler Penn. Railroad	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Chronister		14. MOTHER'S MAIDEN NAME CATHERINE SMALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield State Hospital Records.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease (c)		INTERVAL BETWEEN ONSET AND DEATH Weeks Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-30-43 , 19__, to 10-9-67 , 19__, that (I) (we) last saw the deceased alive on 10-9-67 , 19__, and that death occurred at 3:00 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Glocrite G. Sagisi</i>		22b. DATE SIGNED 10-9-67	
22c. PHYSICIAN'S NAME (Type) Glocrite Sagisi, M.D.		22d. ADDRESS Springfield Hosp. Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/12/67	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	23d. LOCATION (City or Town) (County) (State) BALTO. MD
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		25a. REC'D BY REGISTRAR 300 MACE	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13695						13699					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>Carroll</u>						a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
<u>MANCHESTER</u>						<u>HAMPSTEAD</u>					
c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>						d. STREET ADDRESS <u>110 Main Street</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<u>Longview Nursing Home</u>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<u>DANNIE</u>			<u>Virgie</u>			<u>Cox</u>			<u>10 - 31 19 67</u>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Female</u>		<u>White</u>		<u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		<u>Aug 14 1888</u>		<u>78</u> yrs.		<u>78</u> Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<u>House wife</u>				<u>None</u>		<u>Bolton County Md</u>			<u>U.S.A.</u>		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
<u>John H.C. NARE</u>						<u>MARY SEARS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
<u>no</u>				<u>216-07-2613</u>		<u>Lo Ray NARE Parkton Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u>											
(c) <u>Cardiomyopathy</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. _____ p.m. <u>19</u>				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1, 1965</u> , to <u>Oct 31, 19 67</u> , that (I) (we) last saw the deceased alive on <u>10-27 19 67</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
<u>Joseph E. Bush MD</u>						<u>11-1-67</u>					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
<u>Joseph E. Bush MD</u>						<u>HAMPSTEAD Maryland</u>					
23a. (BURIAL, CREMATION, REMOVAL) (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
<u>BURIAL</u>		<u>11-3-67</u>		<u>FOREST BAPTIST Cemetery</u>				<u>PARKTON Md.</u>			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
<u>John E. Hoff</u>				<u>HAMPSTEAD, Md.</u>				<u>NOV 3 1967</u> <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13700

1 PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE RURAL		c. LENGTH OF STAY IN 1b HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) MT UNION		d. STREET ADDRESS MT UNION	
3 NAME OF DECEASED (Type or print) GEORGE PAUL CROUSE		4 DATE OF DEATH Month 10 - Day 9 - Year 1967	
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 18-1897 TO 70 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		11 BIRTHPLACE (State or foreign country) MARYLAND	
10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ULYSSES CROUSE		14. MOTHER'S MAIDEN NAME BURTON BOND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 217-36-3862	
17. INFORMANT HELEN L CROUSE KEYMAR RURAL MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured Skull + Multiple Fractures + Internal Injuries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1121 (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck over fence taken off on slag pile	
20c. TIME OF INJURY Month Day, Year 2:59 p.m. 10-9-67		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) Farmer	
20e. PLACE OF INJURY (City or town) IMMANTOWN (State) MD		20f. (City or town) Carroll (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W Glenn Speicher		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W GLENN SPEICHER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/11/67	
23c. NAME OF CEMETERY OR CREMATORY LUTHERAN-UNIONTOWN		23d. LOCATION (City or town) Westminster (County) Carroll (State) MD	
24. FUNERAL DIRECTOR D O Hartzler & Sons Union Bridge		25a. REC'D BY REGISTRAR OCT 13 1967	
25b. REGISTRAR'S SIGNATURE William J. Judge		22. DATE SIGNED 10-9-67	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

13697

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13701

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) b. STATE Maryland c. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY "In" 1 mo. 22 da.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 3835 Sequoia Avenue			
3 NAME OF DECEASED (Type or print) First BERNARD Middle GILBERT Last DANGERFIELD, Jr.				4 DATE OF DEATH Month 10 Day 24 Year 1967			
5 SEX Male		6 COLOR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 3-12-44	
				9 AGE (In years last birthday) 23 yrs		IF UNDER 1 YEAR Months 10 Days 12 Hours 24 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13 FATHER'S NAME Bernard G. Dangerfield, Sr.				14 MOTHER'S MAIDEN NAME Carrie Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOCIAL SECURITY NO 1966		17 INFORMANT Address Records, Springfield State Hospital			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending study of brain and tissues DUE TO Fatal Catatonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fatal Catatonia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Glenn Speicher M.D.				22. DATE SIGNED 10-25-67			
EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.				1355 W. Glenn Speicher, M. D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-20-67		23c. NAME OF CEMETERY OR CREMATORY Ba. H. Nat'l Cem.		23d. LOCATION (City or Town) (County) (State) Ba. H. Nat'l Cem. Md.	
24. FUNERAL DIRECTOR Morton E. Dyett F.H.				25a. REC'D BY REGISTRAR Charles Judge			
ADDRESS 1701 LAURENS ST.				DATE OCT 27 1967			

13698

13702

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Woodbine</u>	
c. LENGTH OF STAY IN lb <u>6 Years</u>		d. STREET ADDRESS <u>R.D. 1 - Woods Mill Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 1 - Woods Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Worley Davidson</u>		4. DATE OF DEATH Month Day Year <u>October 6, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1903</u>
9. AGE (In years last birthday) <u>43</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Box Factory</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Wise Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Davidson</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>30-60-0791</u>	
17. INFORMANT Address <u>Mrs. Josephine Davidson R. 1 As 70</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung with cervical and</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>cerebral metastasis. Severe post radium</u> DUE TO (c) <u>and Colboitt reaction; Cardiac arrest from cerebral pressu</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Aug. 1967</u> <u>through</u> <u>10/6/67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>67</u> , to <u>Oct. 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 6, 1967</u> , and that death occurred at <u>5 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Oct. 7, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/9/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharon Baptist</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodbine, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>C. M. Waltz Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT-10-1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13703

13699

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>CARROLL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY in 1d <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA CARROLL COUNTY GENERAL HOSPITAL</u>		e. STREET ADDRESS <u>316 MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>BESSIE MARIE DEAL</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>4</u> - Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 24, 1963</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs <u>4</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>CECIL DEAL</u>		14 MOTHER'S MAIDEN NAME <u>VELMA MCKINNEY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>---</u>	
17 INFORMANT <u>CECIL DEAL</u>		Address <u>316 MAIN ST. NEW WINDSOR, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Contusions & Abrasions</u> (c) <u>8124</u>			INTERVAL BETWEEN DEATH AND DEATH <u>Minutes</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Ran out into main street struck by a going car</u>	
20a. TIME OF INJURY Month, Day, Year <u>5:15</u> Hour a.m. <u>10:4</u> p.m. <u>1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>street</u>	20f. (City or town) <u>New Windsor</u> (County) <u>Carroll</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Glenn Speicher</u>		22. DATE SIGNED <u>10-4-67</u>	
EXAMINER'S NAME (Type) <u>W. GLENN SPEICHER</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address <u>130 E. Main St. Westminister</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>21157 Carroll Md</u>
24. FUNERAL DIRECTOR <u>A. J. [Signature]</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 9 1967</u>	
ADDRESS <u>130 E. Main St. Westminister</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13700

CERTIFICATE OF DEATH

13701

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 27 days.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS Union Bridge Road			
3. NAME OF DECEASED (Type or print) First JOHN Middle (NMN) Last DOE #7				4. DATE OF DEATH Month OCTOBER Day 18 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNDIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-4-1882	
9. AGE (In years last birthday) yrs. 85		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unk.			
14. MOTHER'S MAIDEN NAME Unk.				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.			
16. SOCIAL SECURITY NO 218-54-3912				17. INFORMANT Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH Days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-21-67 , 9:45 PM, 10-18-67 , 19__, that (I) (we) last saw the deceased alive on 10-18-67 19__, and that death occurred at 9:45 PM, from causes and on the date stated above.							
22a. SIGNATURE <i>Octavio A. Ruiz</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-19-67	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-20-67		23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md.	
24. FUNERAL DIRECTOR Harry W. Haight				25a. REC'D BY REGISTRAR Sykesville, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

DATE **OCT 23 1967**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

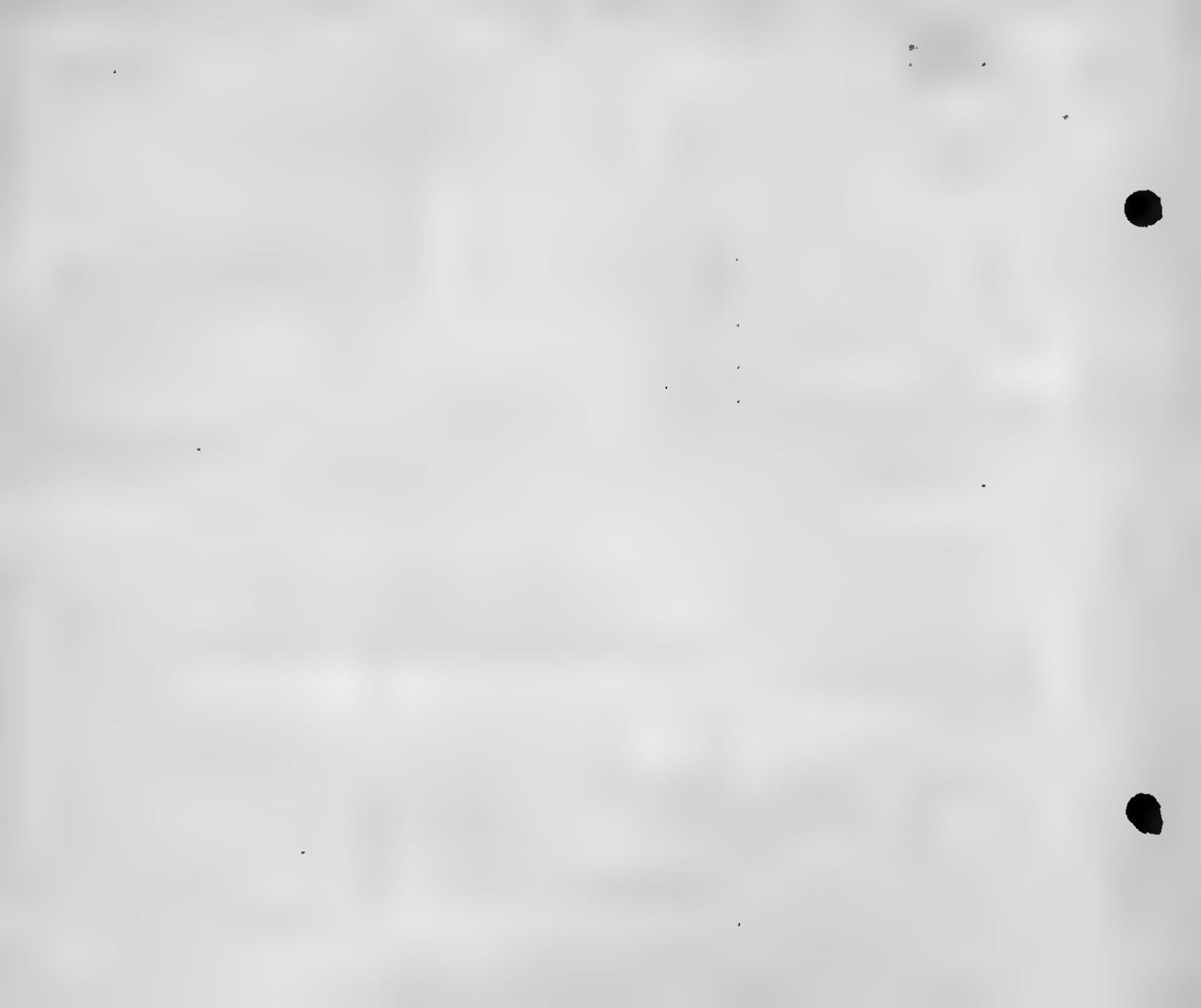
VR A15 (4)
ISM 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13701

13705

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLEBURG c. LENGTH OF STAY IN b. 3 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLEBURG d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF BESSIE AGNES DORSEY (Type or print) First Middle Last		4. DATE OF DEATH OCT 8 1967 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 6 - 1900 66 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		9b. KIND OF BUSINESS OR INDUSTRY SEWING	
10. FATHER'S NAME WILLIAM CARBAUGH		11. BIRTHPLACE (County & State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM CARBAUGH		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-05-7261	
17. INFORMANT CLARA STULTZ		Address MIDDLEBURG MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arthrosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the pancreas			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/19/61 19 to 10/5/67 19, that (I) (we) last saw the deceased alive on 10/4/67 19, and that death occurred at 115R from the causes and on the date stated above.			
22a. SIGNATURE J H CARICOFE 22c. PHYSICIAN'S NAME (Type) J H CARICOFE		22b. DATE SIGNED 10/9/67 22d. ADDRESS UNION BRIDGE MD	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT 11 - 1967	
23c. NAME OF CEMETERY OR CREMATORY WINTERS		23d. LOCATION (City, town or county) (State) NEW WINDSOR RURAL MD	
24. FUNERAL DIRECTOR'S SIGNATURE D D Hartzler & Sons		25a. REC'D BY REGISTRAR OCT 13 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13702

13706

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>6 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u> 3. NAME OF DECEASED (Type or print) <u>Michael (none) Drabic</u> 5. SEX <u>M</u> <u>W</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 27, 1905</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Northampton, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> 13. FATHER'S NAME <u>George Drabic</u> 14. MOTHER'S MAIDEN NAME <u>Tillie Seedor</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>218-07-0752</u> 16. SOCIAL SECURITY NO. <u>218-07-0752</u> 17. INFORMANT <u>Doretta M. Drabic</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>WEEKS</u> (b) <u>YEARS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster Route 7</u> d. STREET ADDRESS <u>Mayberry</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1967</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 20c. TIME OF INJURY Month, Day, Year <u>10/11/1967</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> 21. I certify that (I) (this hospital) attended the deceased from <u>10/11/1967</u> to <u>10/17/1967</u> , that (I) (we) last saw the deceased alive on <u>10/17/1967</u> , and that death occurred at <u>7:43 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Vincent J. Fiocco, Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/17/67</u> 22c. PHYSICIAN'S NAME (Type) <u>Vincent J. Fiocco, Jr.</u> 22d. ADDRESS <u>Westminster, Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10/20/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cemetery</u> 23d. LOCATION (City, town or county) <u>Westminster</u> (State) <u>Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. Hartzler & Sons</u> ADDRESS <u>New Windsor</u> 25a. REC'D BY REGISTRAR <u>OCT 20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13703

CERTIFICATE OF DEATH

13707

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES DAVID FORCE		4 DATE OF DEATH Month Day Year OCTOBER 12 19 67	
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 1-23-06
9 AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Force		14. MOTHER'S MAIDEN NAME Catharine Gitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 577-18-5730	
17 INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, due to probable aspiration DUE TO (b) Right heart failure DUE TO (c) Emphysema		INTERVAL BETWEEN ONSET AND DEATH Days Weeks Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-27-67 , 19 67 , to 10-12-67 , 19 67 , that (I) (we) last saw the deceased alive on 10-12-67 , 19 67 , and that death occurred on 10-12-67 , 19 67 , from causes and on the date stated above.			
22a SIGNATURE Paul G. Ensor, M.D.		22b. DATE SIGNED 10/12/67	
22c. PHYSICIAN'S NAME (Type) Paul G. Ensor, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 10-16-67	23c NAME OF CEMETERY OR CREMATORY Freedom Cemetery	23d LOCATION (City or Town) (County) (State) Sykesville, Md.
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md		25a. RECD BY REGISTRAR Charles Judge	
25b REGISTRAR'S SIGNATURE		DATE OCT 17 1967	



13704

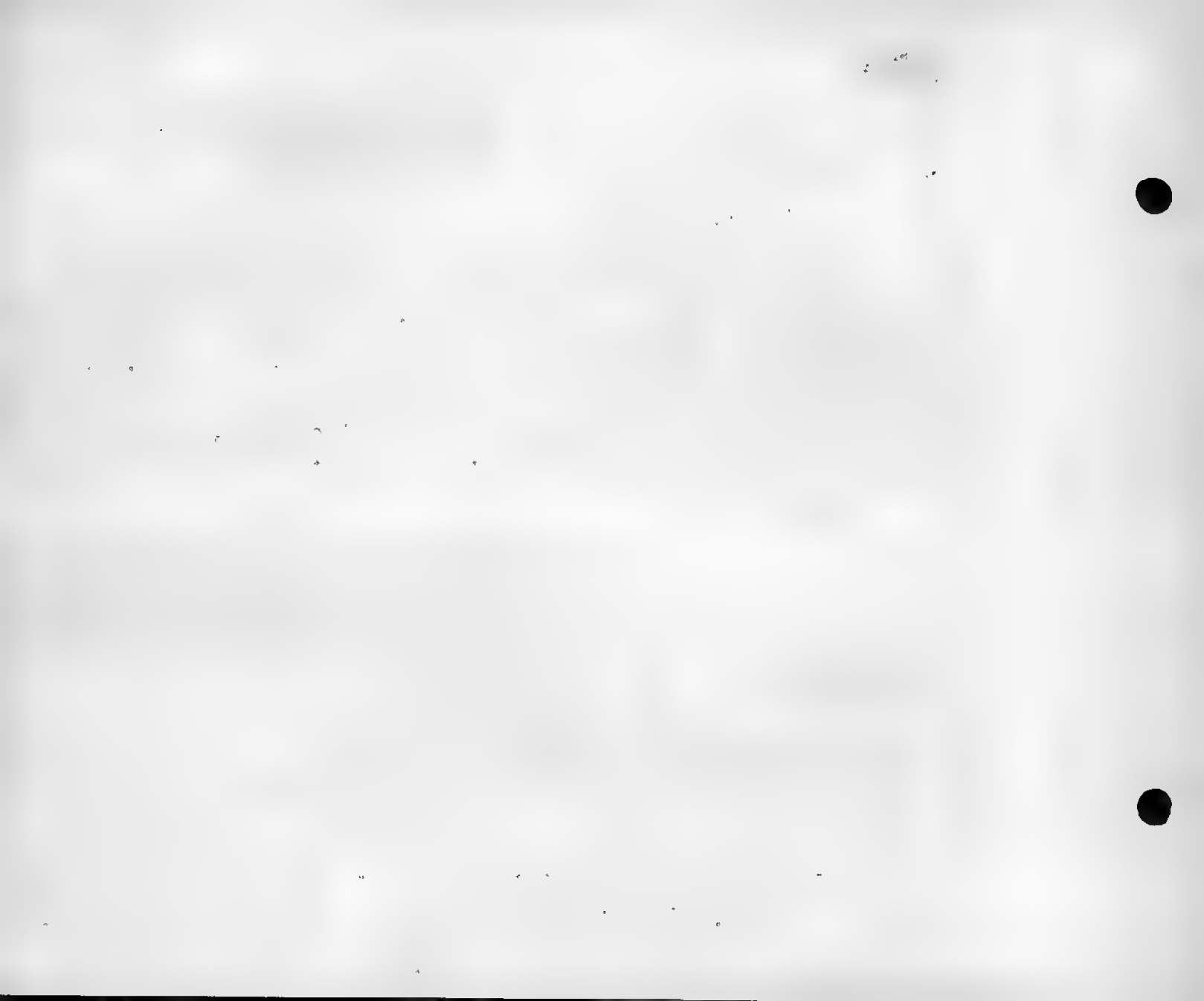
CERTIFICATE OF DEATH

13704

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) 147 Liberty St.		d. STREET ADDRESS 147 Liberty St.	
3. NAME OF DECEASED (Type or print) HOWARD EARL FROUNFELTER		4. DATE OF DEATH Month October Day 23 Year 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Sept. 1894
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Drilling		10b. KIND OF BUSINESS OR INDUSTRY Water	
11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Frounfelter		14. MOTHER'S MAIDEN NAME Catherine Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-14-7761	
17. INFORMANT Mrs. Frances B. Frounfelter, Md.		18. ADDRESS 147 Liberty St., Westminster,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Splenic Flexure DUE TO Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Melancholia & Cachexia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs Several yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 4 , 19 64 , to Oct 23 , 19 67 , that (I) (we) last saw the deceased alive on Sept 16 , 19 67 , and that death occurred at 4:30 M., from causes and on the date stated above.			
22a. SIGNATURE W. Glenn Speicher		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) W. Glenn Speicher, M.D.		22d. ADDRESS Main St. Westminster, Maryland.	
23a. BURIAL, CREMATION, REMOVAL, ETC. Burial		23b. DATE THEREOF 25 Oct. 1967	
23c. NAME OF CEMETERY OR CREMATORY Winters Cemetery		23d. LOCATION (City or Town) (County) (State) Carroll County, Md.	
24. FUNERAL DIRECTOR W. H. Hartzler & Son		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE OCT 26 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13705

Item #9 Film #J393 10/18/67 ph

CERTIFICATE OF DEATH

13709

1. PLACE OF DEATH a. COUNTY Maryland Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster 23 Park Ave.				c. LENGTH OF STAY IN lb Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 23 Park Ave.			
3. NAME OF DECEASED (Type or print) William Henry Griffin Jr.				4. DATE OF DEATH Month October Day 11 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/21/1915	
9. AGE (In years and months) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during last working day, even if retired) Restaurant Operator		10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William H. Griffin Sr.			
14. MOTHER'S MAIDEN NAME Jane E. Thomas				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-24-7945a				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Brain Syndrome DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 7, 1967 to Oct. 11, 1967 , that (I) (we) last saw the deceased alive on Oct. 11, 1967 and that death occurred at 10:30 AM from causes and on the date stated above.							
22a. SIGNATURE Paul G. Ensor MD				22b. DATE SIGNED 10/11/67		22c. PHYSICIAN'S NAME (Type) Paul G. Ensor MD	
22d. ADDRESS Springfield State Hospital Sykesville, Md				22e. REGISTRAR'S SIGNATURE Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/14/67		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEMETERY		23d. LOCATION (City or town) (County) (State) WESTMINSTER RD MD	
24. FUNERAL DIRECTOR J. E. Myers, Jr. Westminster, Md.				25a. REC'D BY REGISTRAR DATE OCT 16 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13706					13710				
1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>			c. LENGTH OF STAY IN 1b <u>3 MOS.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LUCA BAUGH MILL ROAD RT 3</u>					d. STREET ADDRESS <u>257 E. MAIN</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>MAE</u> Last <u>HARMAN</u>					4. DATE OF DEATH Month <u>OCT</u> Day <u>1</u> Year <u>1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 23, 1874</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN WILHIDE</u>					14. MOTHER'S MAIDEN NAME <u>LYDIA MILLER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-20-47290</u>		17. INFORMANT Address <u>RT # 3</u> <u>MRS. ROBERT BAUMGARDNER WESTMINSTER MD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>4 x 2 1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio - Cereb - dis -</u> (c) <u>Arterio sclerosis</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 1955 to Oct 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 30, 1967</u> and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>W. C. JENNETTE</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>OCT 2, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>W. C. JENNETTE MD.</u>					22d. ADDRESS <u>103 E. MAIN ST. WESTMINSTER</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		23d. LOCATION (City, town or county) (State) <u>WESTMINSTER, MD.</u>			
24. FUNERAL DIRECTOR <u>James C. Saffell</u>					ADDRESS <u>234 E. MAIN ST.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
					DATE <u>OCT 3 1967</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>1 month</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster (Rural)</u> d. STREET ADDRESS <u>Rt 3</u>											
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Jesse</u> Last <u>Hull</u>						4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1967</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/29/1880</u>		9. AGE (In years last birthday) <u>86</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Leander Hull</u>						14. MOTHER'S MAIDEN NAME <u>MARY Luckabaugh</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>216-46-8439</u>		17. INFORMANT Address <u>Mr John Hull Westminster, Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>Oct 24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 24</u> , 19 <u>67</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above.																	
22a. SIGNATURE <u>W H Foard</u>						22b. DATE SIGNED <u>10/24/67</u>			22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>								
22d. ADDRESS <u>Manchester, Md 21102</u>						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>RURAL, WESTMINSTER MD</u>									
24. FUNERAL DIRECTOR <u>J. S. Myers Jr. Westminster, Md</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 31 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13708

13712

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Co. General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John W. Jasper</u>		4. DATE OF DEATH <u>10 26 1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-15-1905</u>		9. AGE (In years last birthday) <u>62 yrs.</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Jasper</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Mulhausen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-0884</u>		17. INFORMANT <u>Mrs Barbara Jasper</u>		Address <u>Rexis Road Ferry Hall, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>4x</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>3 hours</u> (c) <u>3 hours</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>10</u> p.m. <u>26</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10/26</u>		20f. (City or town) <u>10/26</u> (County) <u>10/26</u> (State) <u>10/26</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/26</u> , 19 <u>67</u> , to <u>10/26</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/26</u> , 19 <u>67</u> , and that death occurred at <u>3:26</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d. ADDRESS <u>8 Archer St Westminster, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-30-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore Co.</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Judger</u> ADDRESS <u>36</u>				25a. REC'D BY REGISTRAR <u>Charles Judger</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judger</u>			
DATE <u>OCT 30 1967</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

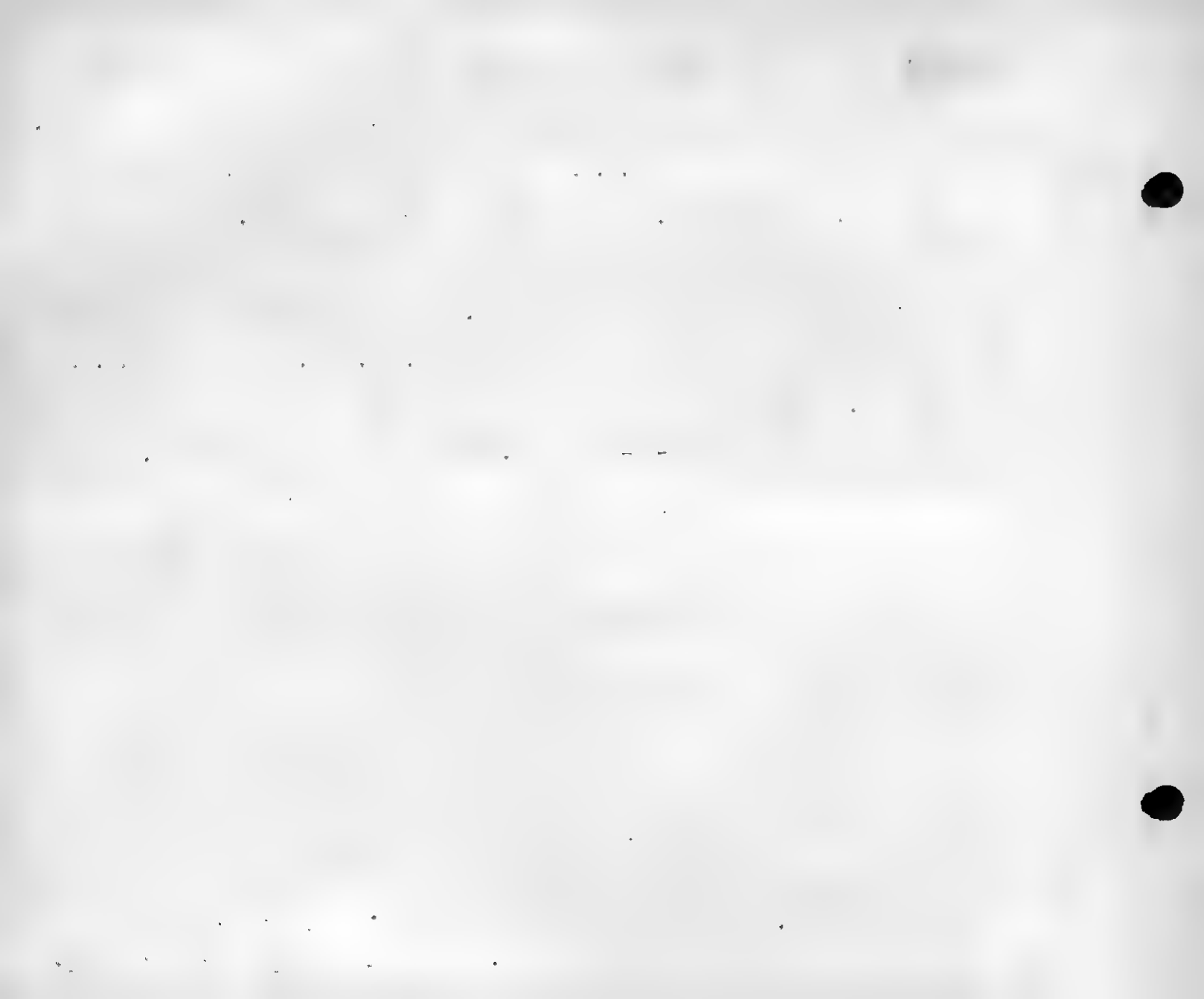
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13713

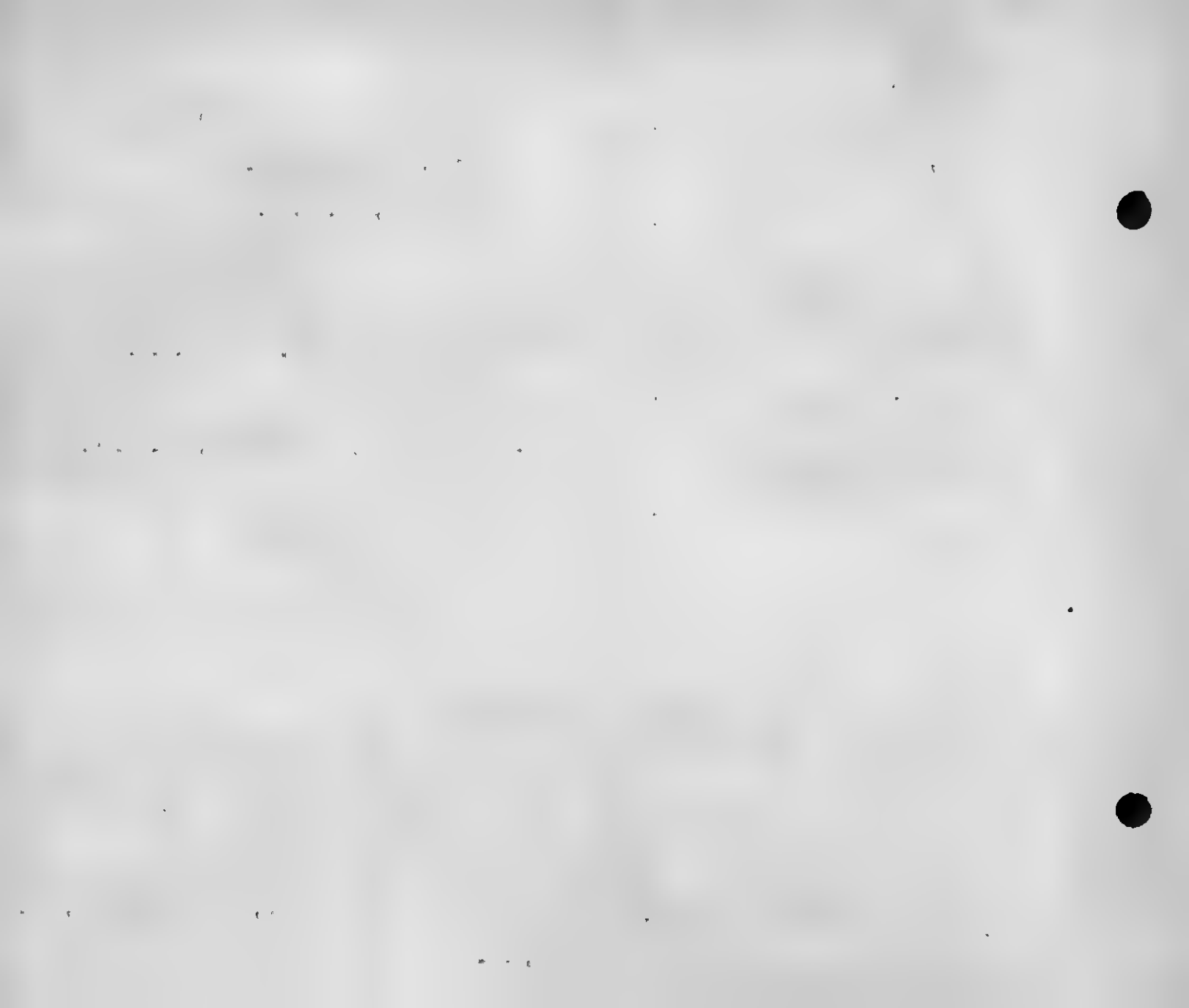
1 PLACE OF DEATH a COUNTY Carroll b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Md. b COUNTY Balto. c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trenton Mill Rd. Upperco	
3 NAME OF DECEASED (Type or print) LILYE BLANCHE JORDAN		4 DATE OF DEATH Month 10 - Day 15 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 2, 1885
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 82
11 BIRTHPLACE (State or foreign country) Balto. Co. Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME David M. Thompson		14 MOTHER'S MAIDEN NAME Agnes Tipton	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 213-28-2604	
17. INFORMANT G. Russell Jordan Hampstead, Md. 21074		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) Coronary thrombosis (acute) Sudden DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Lewis Spencer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Free to use or to change) 635 E. E. Street	
22. DATE SIGNED 10-15-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Oct. 18, 1967	23c NAME OF CEMETERY OR CREMATORY Trenton Cemetery Md.	23d LOCATION (City or town) (County) (State) Westminster, Carroll
24 FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.		25a REC'D BY REGISTRAR OCT 18 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. Page 2 of 2. Page 3 of 2. Page 4 of 2. Page 5 of 2. Page 6 of 2. Page 7 of 2. Page 8 of 2. Page 9 of 2. Page 10 of 2. Page 11 of 2. Page 12 of 2. Page 13 of 2. Page 14 of 2. Page 15 of 2. Page 16 of 2. Page 17 of 2. Page 18 of 2. Page 19 of 2. Page 20 of 2. Page 21 of 2. Page 22 of 2. Page 23 of 2. Page 24 of 2. Page 25 of 2. Page 26 of 2. Page 27 of 2. Page 28 of 2. Page 29 of 2. Page 30 of 2. Page 31 of 2. Page 32 of 2. Page 33 of 2. Page 34 of 2. Page 35 of 2. Page 36 of 2. Page 37 of 2. Page 38 of 2. Page 39 of 2. Page 40 of 2. Page 41 of 2. Page 42 of 2. Page 43 of 2. Page 44 of 2. Page 45 of 2. Page 46 of 2. Page 47 of 2. Page 48 of 2. Page 49 of 2. Page 50 of 2. Page 51 of 2. Page 52 of 2. Page 53 of 2. Page 54 of 2. Page 55 of 2. Page 56 of 2. Page 57 of 2. Page 58 of 2. Page 59 of 2. Page 60 of 2. Page 61 of 2. Page 62 of 2. Page 63 of 2. 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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #16 Film #3354 11/7/67											
13714											
1. PLACE OF DEATH a. COUNTY Carroll				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Sykesville				c. LENGTH OF STAY IN 1b 2 Weeks			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pullens Nursing Home				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Charles First H. Middle Keefer Last				4. DATE OF DEATH Oct 31 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/1898		9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 04 Days 31	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				11b. KIND OF BUSINESS OR INDUSTRY Farms				11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John H. Keefer				14. MOTHER'S MAIDEN NAME Susanna Hahn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO 215-32-5399				17. INFORMANT Mrs. Henry Eckard, Littlestown, Pa. R. D. 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Ca DUE TO Carcinoma of Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 1 yr. DUE TO 1 yr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cachexia, dehydration				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 3 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 22 to Oct 31 , 1967, that (I) (we) last saw the deceased alive on Oct 22 , 1967, and that death occurred at 11 PM , from the causes and on the date stated above.											
22a. SIGNATURE Sari Okutman				22b. DATE 11/1/67				22c. PHYSICIAN'S NAME (Type) Sari Okutman			
22d. ADDRESS Sykesville, Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/3/67				23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery			
23d. LOCATION (City, town or county) Silver Run, Carroll County, Md.				23e. REC'D BY REGISTRAR NOV 3 1967				23f. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				24a. ADDRESS Littlestown, Pa.				24b. DATE NOV 3 1967			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13711

13715

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oaklahoma Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alvina I. King</u>		4. DATE OF DEATH Month Day Year <u>October 1, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1906</u>
9. AGE (In years last birthday) yrs. <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Rheubottom</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-32-9377</u>	
17. INFORMANT <u>Mr. Harry King</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, bronchial pneumonia,</u> <u>1960</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Severe arthritis, Convulsive seizures</u> DUE TO (c) <u>Anemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1960 through 10/1/67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>Oct. 1, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Oct. 1, 1967</u> , and that death occurred at <u>9:00 PM</u> , from causes on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>Oct. 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>White Rock Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sykesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR <u>Sykesville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		DATE <u>OCT 9 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13716

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN Tb 4yrs.3mos.27dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro d. STREET ADDRESS 141 S. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WESLEY Middle KIMEL Last KITCHEN		4. DATE OF DEATH Month OCTOBER Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-1884
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 8 Days 10 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Kitchen		14. MOTHER'S MAIDEN NAME Laura Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 219-20-2632	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Massive bilateral pneumonia 475A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-13-63 to 10-10-67 , 19 10-10-67 , that (I) (we) last saw the deceased alive on 10-10-67 19 10-10-67 , and that death occurred at 10:30 PM from causes and on the date stated above.			
22a. SIGNATURE Glocrito G. Sagisi 22c. PHYSICIAN'S NAME (Type) Glocrito G. Sagisi, M. D.		22b. DATE SIGNED 10-10-67 22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, or other disposition (Specify) UNKNOWN	23b. DATE THEREOF 10-13-1967	23c. NAME OF CEMETERY OR CREMATORY Falling Waters Pres. Cemetery-Spring Mills, Berkeley, W.Va.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR N.K. Brown Brown Funeral Home		25a. REC'D BY REGISTRAR DATE OCT 16 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13712

Item #24 Film #G39L 12/30/67

CERTIFICATE OF DEATH

13712

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 8yrs. 8mons 11days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 21231	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2208 Fleet St. Sykesville, Maryland	
3. NAME OF DECEASED (Type or print) First Felix Middle Joseph Last Kryger		4. DATE OF DEATH Month 10 Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-06
9. AGE (in years last birthday) 61 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Kryger		14. MOTHER'S MAIDEN NAME Marynna Koscinski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 215-18-9063	
17. INFORMANT Springfield Hospital Records, Sykesville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Mesenteric Thrombosis DUE TO (b) Pulmonary Emphysema DUE TO (c) Obesity		INTERVAL BETWEEN ONSET AND DEATH Hours Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Catatonic Type.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that it (this hospital) attended the deceased from 1-26-59 , 19 59 , to 10-14 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-14- 19 67 , and that death occurred at 1:25A M, from causes and on the date stated above.			
22a. SIGNATURE Suha Ozgun		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Suha Ozgun		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-1967	
23c. NAME OF CEMETERY OR CREMATORY Holy Rosary		23d. LOCATION (City or Town) (County) (State) Baltimore, County, Maryland	
24. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Avenue		25a. REC'D BY REGISTRAR OCT 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



13715

CERTIFICATE OF DEATH

15216

1 PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 1 Hr d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL COUNTY GEN. HOSP.		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 153 d. STREET ADDRESS Union Bridge, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY GIRL First Middle Last L B SCALLIST		4. DATE OF DEATH Month Day Year 10 19 1967	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years lost birthday) Yrs 1 Months 5 Days 1 Hours 5 Min
11 BIRTHPLACE (County & State, or foreign country) CARROLL COUNTY		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME JOHN ALLEN (B) SCALLIST		14. MOTHER'S MAIDEN NAME BLACK, NANCY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —		16. SOCIAL SECURITY NO. —	17. INFORMANT — Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO (b) IMMATURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) — DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21 I certify that (I) (this hospital) attended the deceased from 10/19 , 19 67 , to 10/19 , 19 67 , that (I) (we) last saw the deceased alive on 10/19 , 19 67 and that death occurred on 10/19 , 19 67 from causes and on the date stated above			
22a. SIGNATURE Sherman Chang		22b. DATE SIGNED 10/19/67	
22c. PHYSICIAN'S NAME (Type) Sherman, Chang, M.D.		22d. ADDRESS Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) Disposed by Hosp. 20 Oct 67 Carroll County Gen. Hosp. Westminster Carroll Md
24. FUNERAL DIRECTOR GLENN A. FISHER Administrator		25a. REC'D BY REGISTRAR NOV 10 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. What is the purpose of the study?

1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13714

13718

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
2504 Moore Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First SARAH Middle HELEN Last LEBO | | | | 4. DATE OF DEATH
Month OCTOBER 27, Day 19 Year 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-4-1876 | 9. AGE (In years last birthday) yrs. 91 | 10. IF UNDER 1 YEAR
Months 10 Days 27 Hours 11 Mm. 20 | | 11. IF UNDER 24 HRS
Hours 11 Mm. 20 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Factory worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Shoe Mfg. | | 11. BIRTHPLACE (County & State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown Martin L. Helsler | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
183-12-2103-A | | 17. INFORMANT
Address Records, Springfield State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO 4200
Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bronchopneumonia
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Years
Days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS ALTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-26-67 , 19 to 10-27-67 , 19, that (I) (we) last saw the deceased alive on 10-27-67 , 19, and that death occurred at 11:20 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Dr. Antonius Glahn, M.D.</i> | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10-27-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Antonius Glahn, M. D. | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-30-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion | | 23d. LOCATION (City or Town) (County) (State)
Carlisle Pa. | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd., Baltimore | | | | 25a. REC'D BY REGISTRAR
OCT 30 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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13716

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13719

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1 PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 31yrs. 6mos. 27dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown
d. STREET ADDRESS Unknown
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED
(Type or print) First Middle Last
CAMILLA (NMN) LINDERMAN | | | | 4. DATE OF DEATH
Month Day Year
OCTOBER 6 1967 | | | |
| 5 SEX
Female | | 6 COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1884? 83? | |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9 AGE (In years last birthday) yrs Months Days Hours Min
83? 83? 83? 83? 83? | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
----- | | 17. INFORMANT
Address
Records, Springfield State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 0042
(b) Moderately advanced pulmonary tuberculosis, probably inactive
(c) inactive | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Years | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Schizophrenic reaction, paranoid type | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-9-36 , 10-6-67 , 19__, that (I) (we) last saw the deceased alive on 10-6-67 19__, and that death occurred at 10:55 PM , from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE
Julian Radzykewycz, M.D. | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10-6-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Julian Radzykewycz, M. D. | | | | 22d. ADDRESS
Springfield State Hospital Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, Md | |
| 24. FUNERAL DIRECTOR
Frank J. Kewell, Vice President | | ADDRESS
1000 N. E. 10th St. | | 25a. REC'D BY REGISTRAR
DATE OCT 10 1967 | | 25b. REGISTRAR'S SIGNATURE
John L. Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

13720

13717

CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville | | c. LENGTH OF STAY IN lb
46 yrs 10 mo | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
City, Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
731 E. 22nd Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Edward Joseph Lynch | | | | 4. DATE OF DEATH
Month 10 Day 14 Year 19 67 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
12 - 15 - 1884 | | 9. AGE (In years last birthday)
82 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Brakeman | | 10b. KIND OF BUSINESS OR INDUSTRY
Rail Road | | 11. BIRTHPLACE (County & State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Martin J. Lynch | | | | 14. MOTHER'S MAIDEN NAME
Mary Shannahan | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
220-54-9129 | | 17. INFORMANT
Address
Springfield Hospital records, Sykesville | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Heart failure
DUE TO (b) Old extensive myocardial infarction
DUE TO (c) Bilateral bronchopneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
weeks
Years
Days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Schizophrenic Reaction, Hebephrenic type. | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from Dec 15 , 19 19 , to 10-14- , 1967, that (2) (we) last saw the deceased alive on 10-14- , 1967, and that death occurred at 10:45 PM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Octavio Ruiz</i> | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10-15-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Octavio Ruiz, M.D. | | | | 22d. ADDRESS
Springfield State Hospital Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/18/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cem. | | 23d. LOCATION (City or Town) (County) (State)
3310 Taylor-Ave Md. | |
| 24. FUNERAL DIRECTOR
<i>John J. Cowan</i> | | | | 25a. REC'D BY REGISTRAR
OCT 17 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Cowan</i> | |

23, ml.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS-1. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13718

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13721

| | | | |
|--|---------------------------------|--|---|
| 1 PLACE OF DEATH
a COUNTY <u>Carroll</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Westminster</u> | | c LENGTH OF STAY IN IS <u>?</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d STREET ADDRESS
<u>110 N. Calhoun Street</u> | |
| e IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED
(Type or print) First Middle Last
<u>HARVEY R. MARING</u> | | 4 DATE OF DEATH
Month Day Year
<u>10-18-67</u> | |
| 5 SEX
<u>Male</u> | 6 COLOR OR RACE
<u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 AGE (In years last birthday)
<u>32</u> yrs |
| 9 IF UNDER 1 YEAR
Months Days Hours Min
<u>10-18-67</u> | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Registered Nurse</u> | |
| 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country)
<u>Carroll Co., Md.</u> | |
| 12 CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13 FATHER'S NAME
<u>Ralph D. Maring</u> | |
| 14 MOTHER'S MAIDEN NAME
<u>Bessie W. Pickett</u> | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
<u>Yes 1955 to 1957</u> | |
| 16 SOCIAL SECURITY NO
<u>218-32-2076</u> | | 17 INFORMANT
Address
<u>Mr. Ralph D. Maring Westminster, Md.</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Gunshot wound Skull</u>
<u>(Shotgun) self inflicted</u>
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, item 18)
<u>apparently placed gun at it temple & pulled trigger</u> | |
| 20c TIME OF INJURY Month Day Year
Hour am pm <u>?</u> <u>10-18-67</u> | | 20d INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.)
<u>Roadside</u> | | 20f (City or town) (County) (State)
<u>CARROLL Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>W. Glenn Speicher</u> | | 22 DATE SIGNED
<u>10-18-67</u> | |
| EXAMINER'S NAME (Type)
<u>W. Glenn Speicher</u> | | 23a LOCATION (City or Town) (County) (State)
<u>13500 Westminister Md</u> | |
| 23b DATE THEREOF
<u>10/21/1967</u> | | 23c NAME OF CEMETERY
<u>Wilfield Church Of God Carroll Co., Md.</u> | |
| 23d BURIAL OR CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23e RECD BY REG STRAR
DATE
<u>OCT 23 1967</u> | |
| 24 FUNERAL DIRECTOR
ADDRESS
<u>C. M. Waltz ex 741 Sikesville, Md.</u> | | 25b REG STRAR'S SIGNATURE
<u>Charles Judge</u> | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban posters. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13719

CERTIFICATE OF DEATH

13722

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Sykesville
c. LENGTH OF STAY IN TB
4 mos. 23 da. | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/>
a. STATE
Maryland
b. COUNTY
Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ellicott City
d. STREET ADDRESS
39 Maryland Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First WILBUR Middle HARRISON Last MARTIN | | 4 DATE OF DEATH
Month 10 Day 9 Year 19 67 | |
| 5 SEX
Male | 6 COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-1-1879
9 AGE (In years last birthday)
88 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | |
| 11. BIRTHPLACE (County & State, or foreign country)
Unknown | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Unknown | | 16 SOCIAL SECURITY NO.
214-18-1688 | |
| 17. INFORMANT
Records, Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4221
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic brain syndrome associated with senile brain disease with psychotic reaction. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 16, 19 67 to October 9, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 9, 19 67 , and that death occurred 11:20 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Julian Radzykewycz</i> M.D. | | 22b. DATE SIGNED
10-9-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Julian Radzykewycz, M.D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland 21784 | |
| 23a. BURIAL, CREMATION, REMOVAL, (Specify)
BURIAL | 23b. DATE THEREOF
10-21-67 | 23c. NAME OF CEMETERY OR CREMATORY
Freedom Cemetery | 23d. LOCATION (City or Town) (County) (State)
Sykesville, Md. |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | 25a. REC'D BY REGISTRAR
Sykesville, Md.
25b. REGISTRAR'S SIGNATURE
Oct 23 1967 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--------------------------------------|---|---|
| 13720 | | 13723 | |
| 1 PLACE OF DEATH
a. COUNTY
Carroll
MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) ✓
a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN ib
3yrs. 25dys. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First JOSEPH Middle V. Last MINITOR | | 4. DATE OF DEATH
Month OCTOBER Day 25 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-22-1899 |
| 9. AGE (In years last birthday)
67 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | |
| 11. BIRTHPLACE (County & State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown- Michael Minitor | | 14. MOTHER'S MAIDEN NAME
Unknown Cress | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
213-10-2657-A | |
| 17. INFORMANT
Records, Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO (b) _____
DUE TO (c) Infected gangrenous decubitus ulcers | | INTERVAL BETWEEN ONSET AND DEATH
Years
Months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
CBS assoc. with cerebral arteriosclerosis, with psychotic reaction | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-30-64 , 19 , to 10-25-67 , 19 , that (I) (we) last saw the deceased alive on 10-25-67 , 19 , and that death occurred at 6:35 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Octavio A. Ruiz</i> | | 22b. DATE SIGNED
10-25-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Octavio A. Ruiz, M.D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
10-28-67 | 23c. NAME OF CEMETERY OR CREMATORY
Cathedral | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. |
| 24. FUNERAL DIRECTOR
Frank H. Seitz | | 25a. REC'D BY REGISTRAR
814 N 36th St. Balto City Md. | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

OCT 30 1967

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13721
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>
c. LENGTH OF STAY in 1b <u>1 Month</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Co. Gen. Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u>
b. COUNTY <u>Howard</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>
d. STREET ADDRESS <u>Day Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Grace</u> Middle <u>Annie</u> Last <u>Noyes</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>14</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-13-1896</u> | |
| 9. AGE (In years last birthday) <u>71</u> yrs | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> | |
| 11. IF UNDER 24 HRS. Hours <u>14</u> Min. <u>1967</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jacob Markley</u> | | 14. MOTHER'S MAIDEN NAME <u>Augusta Quarengesser</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Mr. Harvey Noyes - Sykesville, Md.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR INSUFFICIENCY</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CEREBRAL THROMBOSIS</u>
DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>IMMED</u>
<u>6 WKS.</u>
<u>YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> <u>1967</u> , to <u>10/14</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> <u>1967</u> , and that death occurred at <u>6:25 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Vincent J. Finco Jr.</u> M.D. | | 22b. DATE SIGNED <u>10/14/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Vincent J. Finco Jr.</u> | | 22d. ADDRESS <u>Westminster, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10-17-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>LAKE VIEW CEMETERY</u> | | 23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Haight</u> | | 25a. REC'D BY REGISTRAR <u>OCT 19 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13722

CERTIFICATE OF DEATH

13725

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE <u>Id.</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rural Sykesville</u> | | | | c. LENGTH OF STAY IN ID <u>15 Years</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gaither Road</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Clara Louise Peiffer</u> | | | | 4. DATE OF DEATH <u>Oct. 1, 1967</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-23-1899</u> | |
| 9. AGE (In years last birthday) <u>68 yrs</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Ill.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Oscar Sperber</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Elize Tietze</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>-----</u> | | | |
| 16. SOCIAL SECURITY NO <u>-----</u> | | | | 17. INFORMANT <u>Mr. Webb Peiffer</u> Address <u>Sykesville, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>
DUE TO <u>4200</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>
DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>few min.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) person attended the deceased from <u>7/April/68</u> , 19 <u>68</u> , to <u>1/Oct/67</u> , 19 <u>67</u> , that (I) had saw the deceased alive on <u>1/Oct/67</u> , 19 <u>67</u> , and that death occurred at <u>7:30AM</u> from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | 22b. DATE SIGNED <u>1/Oct/67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M. D.</u> | |
| 22d. ADDRESS <u>Box 54, RD #2, Sykesville, Md. 21784</u> | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10-4-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Sykesville Md</u> | |
| 24. FUNERAL DIRECTOR <u>Harry W. Haight</u> <u>Sykesville, Md.</u> | | | | 25a. RECD BY REGISTRAR <u>[Signature]</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 13722 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL CO.</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>
c. LENGTH OF STAY IN b. <u>1 MO. +</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GEN. HOSPITAL</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u>
b. COUNTY <u>CARROLL</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>
d. STREET ADDRESS <u>30 PARK AVE.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>HERBERT MELVIN PHILLIPS</u>
First Middle Last | | | | | | 4. DATE OF DEATH <u>OCT. 3 1967</u>
Month Day Year | | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JUNE 4, 1894</u> | | 9. AGE (In years last birthday) <u>73</u> yrs. | | 10. IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL BUS OWNER AND DRIVER</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u> | | |
| 13. FATHER'S NAME <u>JAMES ALFRED PHILLIPS</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>ALMIRA FISHER</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | | | | | 16. SOCIAL SECURITY NO. <u>219-14 9527A</u> | | | 17. INFORMANT <u>MRS. ETHEL S. PHILLIPS</u> Address <u>SAME ADDRESS</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Arteriosclerotic Heart Disease</u>
Conditions, if any, which gave rise to immediate cause (b) <u>4 years</u>
(a), stating the underlying cause last. (c) DUE TO | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] | | | | | |
| 20c. TIME OF INJURY
Hour <u>19</u> a.m. p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>Oct 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 3, 1967</u> , and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>John S. Harshey</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED <u>10/3/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u> | | | | | | 22d. ADDRESS <u>8 Archer St. Westminster, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>OCT. 6, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEMETERY</u> | | 23d. LOCATION (City, town or county) <u>WESTMINSTER, MD.</u> | | (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>Oct 5 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



13724

CERTIFICATE OF DEATH

13727

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN lb
10 mos. 7 yrs. 14 days. | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | d. STREET ADDRESS
514 E. Pratt St.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
JOSEPH (NN) REINFELTS | | 4. DATE OF DEATH
Month OCTOBER Day 4 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-10-1890 |
| 9. AGE (In years last birthday)
77 yrs | | 10. IF UNDER 1 YEAR
Months 7 Days 14 Hours 14 Min 5 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Porter (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Reinfelts | | 14. MOTHER'S MAIDEN NAME
Birdie Killmeyer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-12-7425 | |
| 17. INFORMANT
Records, Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cor Pulmonale
DUE TO (b) Pulmonary emphysema
DUE TO (c) Old, arrested pulmonary tuberculosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 0-2 | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CBS assoc. with other CNS syphilis, without qualifying phrase
Old, arrested pulmonary tuberculosis | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 11-20-59 , 19 19 , to 10-4-67 , 19 19 , that (I) (we) last saw the deceased alive on 10-4-67 , 19 19 , and that death occurred at 11:15 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Octavio A. Ruiz | | 22b. DATE SIGNED
10-5-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Octavio A. Ruiz, M.D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10/7/67 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | 23d. LOCATION (City or town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Ullrich Funeral Home 4210 Belair Road. | | 25a. REC'D BY REGISTRAR
DATE OCT 9 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13728

13728

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)
a. STATE
Maryland
b. COUNTY
Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN lb
2mos. 28dys. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | e. STREET ADDRESS
111 Main St. | |
| 3. NAME OF DECEASED
(Type or print)
BERNICE OPHELIA REPP | | 4. DATE OF DEATH
Month Day Year
OCTOBER 31 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-16-1894 |
| 9. AGE (n years lost birthday) yrs.
73 | | 10. IF UNDER 1 YEAR Months Days Hours Min.
73 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Philip Sherman Carnell | | 14. MOTHER'S MAIDEN NAME
Rebecca Florence Dermitt | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-52-0276 | |
| 17. INFORMANT
Records, Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
DUE TO
(b) Arteriosclerotic heart disease
DUE TO
(c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
CBS assoc. with cerebral arteriosclerosis, with neurotic reaction | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-3-67 , 19 to 10-31-67 , 19, that (I) (we) last saw the deceased alive on 10-31-67 , 19, and that death occurred at 10:25 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Antonius Glahn M.D. | | 22b. DATE SIGNED
11-1-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Antonius Glahn, M. D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Nov. 4, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Philos Cemetery | 23d. LOCATION (City or Town) (County) (State)
Westernport Alleg. Md |
| 24. FUNERAL DIRECTOR
W. Harold Fredlock Piedmont, W.Va. | | 25a. REC'D BY REGISTRAR
NOV 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | 25c. JUDGE
[Signature] | |



13726

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1 PLACE OF DEATH
a. COUNTY Carroll
MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland
b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville, Md. | | c. LENGTH OF STAY IN 1b
3Yrs. 4 Mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore, 21229 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
14649 Rokeby Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Theodore Anthony Rettaliata
First Middle Last | | | | 4. DATE OF DEATH
Oct 8, 1967
Month Day Year | | | |
| 5 SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
12-1-86 | | 9 AGE (In years last birthday)
80 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stenographer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country)
Maryland | | 12 CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John J. Rettaliata | | | 14 MOTHER'S MAIDEN NAME
Julia V. | | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO
212-01-4551 | | 17. INFORMANT
Hospital Records
Address | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Advanced Generalized arteriosclerosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 'o m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from 6-2 , 19 64 , to 10-8 , 19 67 , that (I) (we) last saw the deceased alive on 10-8-67 , 19 67 , and that death occurred at 1 P.M. , from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Orlando C. Ramos | | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10-8-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Orlando C. Ramos | | | | 22d. ADDRESS
Springfield State Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/10/67 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Wm. Tichner & Sons | | | | 25a. REC'D BY REGISTRAR
Oct 11 1967 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13721

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
6yrs. 5mos. 8dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
107 Albemarle St.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED
(Type or print)
CAROLINE VIRGINIA RHODES | | 4 DATE OF DEATH
Month Day Year
OCTOBER 5 19 67 | |
| 5 SEX
Female | 6. COLOR OR RACE
/White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-10-1888 |
| 9. AGE (In years last b.irthday)
79 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Raymond E. Rhodes | | 14. MOTHER'S MAIDEN NAME
Josephine V. Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO
Unk. | |
| 17. INFORMANT
Records, Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO
(b) Generalized arteriosclerosis
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CBS assoc. with senile brain disease, with psychotic reaction | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
Years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4-27-61 , 19 pp 10-5-67 , 19 , that (I) (we) last saw the deceased alive on 10-5-67 19 , and that death occurred at 5:00 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Antonijs Glahn M.D. | | 22b. DATE SIGNED
10-5-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Antonijs Glahn, M. D. | | 22d. ADDRESS
Springfield State Hospital, Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10-14-67 | 23c. NAME OF CEMETERY OR CREMATORY
Freedom Cemetery | 23d. LOCATION (City or Town) (County) (State)
Sykesville, Md |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | 25a. RECD BY REGISTRAR
OCT 17 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove or destroy pages 1, 2, and 3. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13731

13728

CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
19 yrs. 3 mos. | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | d. STREET ADDRESS
3032 Boston St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
SOPHIE FRANCES SAKOWICZ | | | 4. DATE OF DEATH
Month OCTOBER Day 14 Year 1967 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-18-14 | 9. AGE (In years last birthday)
53 yrs. | IF UNDER 1 YEAR
Months 10 Days 19 Hours 67 Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Factory Worker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 13. FATHER'S NAME
Anthony Sakowicz | | | 14. MOTHER'S MAIDEN NAME
Angeline Noyai | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO
217-09-8005 | | 17. INFORMANT
Address
Records, Springfield State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Extensive bilateral bronchopneumonia
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Schizophrenic reaction, paranoid type | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7-14-48 , 19____, to 10-14-67 , 19____, that (I) (we) last saw the deceased alive on 10-14-67 , 19____, and that death occurred at 11:30 AM from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<i>Antonius Glahn, M.D.</i> | | | 22b. DATE SIGNED
10-18-67 | | |
| 22c. PHYSICIAN'S NAME (Type)
Antonius Glahn, M.D. | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10-20-67 | 23c. NAME OF CEMETERY OR CREMATORY
Freedom Cemetery | 23d. LOCATION (City or Town)
Sykesville | (County) _____ (State) Md. | |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | | 25a. RECD BY REGISTRAR
Sykesville, Md. | 25b. REGISTRAR'S SIGNATURE
Oct 22, 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13729

CERTIFICATE OF DEATH

13732

| | | | |
|--|----------------------------------|---|--|
| 1 PLACE OF DEATH
a. COUNTY
Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
6 months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | d. STREET ADDRESS
3309 Elgin Ave. | |
| 3 NAME OF DECEASED
(Type or print)
SOPHIA CATHERINE SAUER | | 4. DATE OF DEATH
Month 10 Day 26 Year 19 67 | |
| 5 SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7 - 28 - 80 |
| 9 AGE (In years last birthday)
87 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | |
| 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | | 11 BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
George L. Bents (dec.) | |
| 14. MOTHER'S MAIDEN NAME
unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | |
| 16. SOCIAL SECURITY NO.
214-20-9333 | | 17. INFORMANT
Hospital Records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
4221
IMMEDIATE CAUSE (a) Generalized Arteriosclerotic Cardio-vascular Disease
DUE TO (b) _____
stating the underlying cause last. (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5 - 8 , 19 67 to 10 - 26 , 19 67 that (I) (we) last saw the deceased alive on 10 - 26 , 19 67 , and that death occurred at 10:PM , from causes and on the date stated above | | | |
| 22a. SIGNATURE
D. Alfredo M. Labrit | | 22b. DATE SIGNED
10-26-67 | |
| 22c. PHYSICIAN'S NAME (Type)
D. Alfredo M. Labrit | | 22d. ADDRESS
Springfield State Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-30-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24 FUNERAL DIRECTOR
G. Howard Strong 3207 W. North Ave., | | 25a. REC'D BY REGISTRAR
OCT 30 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13730

CERTIFICATE OF DEATH

13733

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY --- | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville, | | c. LENGTH OF STAY IN 1b
16 days
24 yrs./9 mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21230 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
1108 E. Fort Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Ruth Elaine SCHWABLINE | | | | 4. DATE OF DEATH
Month Day Year
October 21, 1967 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-13-23 | | 9. AGE (in years last birthday)
44 yrs. | 10. UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Earl Schwabline | | | | 14. MOTHER'S MAIDEN NAME
Atlantic Jones | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Springfield State Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)
DUE TO (c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS with congenital spastic paraplegia without qualifying phrase. Mental retardation, severe. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
days | |
| 19. WAS A TOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-5-43 , 19 to 10-21-67 , 19, that (I) (we) last saw the deceased alive on 10-21-67 , 19, and that death occurred at 4:25 p.m. from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Antonius Glahn</i> M.D. | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10-21-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Antonius Glahn, M.D. | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland 21784 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10 23 67 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION (City or Town) (County) (State)
Brooklyn, A. A. Co. Md. | |
| 24. FUNERAL DIRECTOR
Mc Cully | | | | 25a. REC'D. BY REGISTRAR
DATE OCT 23 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>
c. LENGTH OF STAY IN 1b <u>45 YRS.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL G. GEN. HOSPITAL</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>
d. STREET ADDRESS <u>17 CHASE ST.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>CHARLES LEWIS SEIPP SR.</u> | | 4. DATE OF DEATH <u>10 15 1967</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC. 11, 1893</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL Co. MD.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>LEWIS SEIPP</u> | |
| 14. MOTHER'S MAIDEN NAME <u>ROSIN DRECHSLER</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give year or dates of service) <u>WWI</u> | |
| 16. SOCIAL SECURITY NO. <u>215-34-1073</u> | | 17. INFORMANT <u>MRS. MELVIN I. BLIZZARD, WESTMINSTER, MD.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
Conditions, if any, which gave rise to immediate cause (b) <u>MYOCARDIAL INFARCTION</u>
(c) <u>HYPERTENSIVE ARTERIO SCLEROTIC DISEASE</u>
HEART
INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u>
YEARS | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/13, 1967</u> to <u>10/15, 1967</u> , that (I) (we) last saw the deceased alive on <u>10/15, 1967</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Vincent J. Kroca Jr.</u> M.D. | | 22b. DATE SIGNED <u>10/15/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10/18/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY RURAL, WESTMINSTER, MD.</u> | | 23d. LOCATION (City, town or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Moyer Jr. Westminster, Md.</u> | | 25a. REC'D BY REGISTRAR <u>OCT 19 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

13732

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13735

| | | | |
|--|---------------------------------|--|---|
| 1 PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Ohio b. COUNTY Alleg. Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
1mo 26da | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cleveland | |
| 3 NAME OF DECEASED
(Type or print) Harry Allen Shaffer | | d. STREET ADDRESS
1421 W. 84th Street | |
| f. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED
(Type or print) Harry Allen Shaffer | | 4. DATE OF DEATH
Month October Day 15 Year 1967 | |
| 5 SEX
Male | 6 COLOR OR RACE
White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH
5-2-27 |
| 9 AGE (In years last birthday) yrs
40 | | 10 IF UNDER 1 YEAR
Months Days Hours Min | 11 IF UNDER 24 HRS
Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Illinois | |
| 11 BIRTHPLACE (State or foreign country)
Illinois | | 12 CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Harry Shaffer | | 14. MOTHER'S MAIDEN NAME
Edna Keeler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
312-22-0662 | |
| 17 INFORMANT
Springfield State Hosp. Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
1021
DUE TO Cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Massive Pulmonary Emboli
(c) Commuted fracture distal end of tibia and fibula left. | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
9-12-67 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
Jumped out skinning room window | |
| 20c. TIME OF INJURY Month, Day, Year
10:00 p.m. 9/12/67 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)
HOSPITAL | | 20f. (City or town) (County) (State)
Sykesville Carroll Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22. DATE SIGNED
10-15-67 | |
| ACTUAL SIGNATURE W. Glenn Speicher M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) W. Glenn Speicher, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a. B. J. REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
10-19-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Greenwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
WESTMINSTER CARROLL | |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | 25a. READ BY REGISTRAR
OCT 17 1967 | |
| ADDRESS
Sykesville, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



CERTIFICATE OF DEATH

13736

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH
a. COUNTY CARROLL MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WESTMINSTER | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WESTMINSTER | |
| c. LENGTH OF STAY IN 1b
YEARS | | d. STREET ADDRESS
1 HERSH AVE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1 HERSH AVE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED
(Type or print)
First Middle Last
ALLIE I SHERFEY | | 4 DATE OF DEATH
Month Day Year
OCT 17 1967 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
NOV 24-1886 |
| 9. AGE (in years last birthday)
80 yrs | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEKEEPER | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
EDWARD HAHN | | 14. MOTHER'S MAIDEN NAME
ANNA EARLY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO
216-43-5848 | |
| 17. INFORMANT
JOHN SHERFEY | | Address
WESTMINSTER MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
4211 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 10 , 19 67 , to Oct 17 , 19 67 , that (I) (we) last saw the deceased alive on Oct 17 , 19 67 , and that death occurred at 4:30 PM , from causes and on the date stated above | | | |
| 22a. SIGNATURE
Julius Chepko | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED
10/19/67 |
| 22c. PHYSICIAN'S NAME (Type)
Julius Chepko | | 22d. ADDRESS
85 1/2 W. Green St Westminister Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
OCT 20-1967 | 23c. NAME OF CEMETERY OR CREMATORY
MT HOPE | 23d. LOCATION (City or Town) (County) (State)
WOODSBORO MD |
| 24. FUNERAL DIRECTOR
D. H. Hartzler & Sons | | ADDRESS
New Windsor | 25a. REC'D BY REGISTRAR
DATE OCT 20 1967 |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MF
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13734

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13737

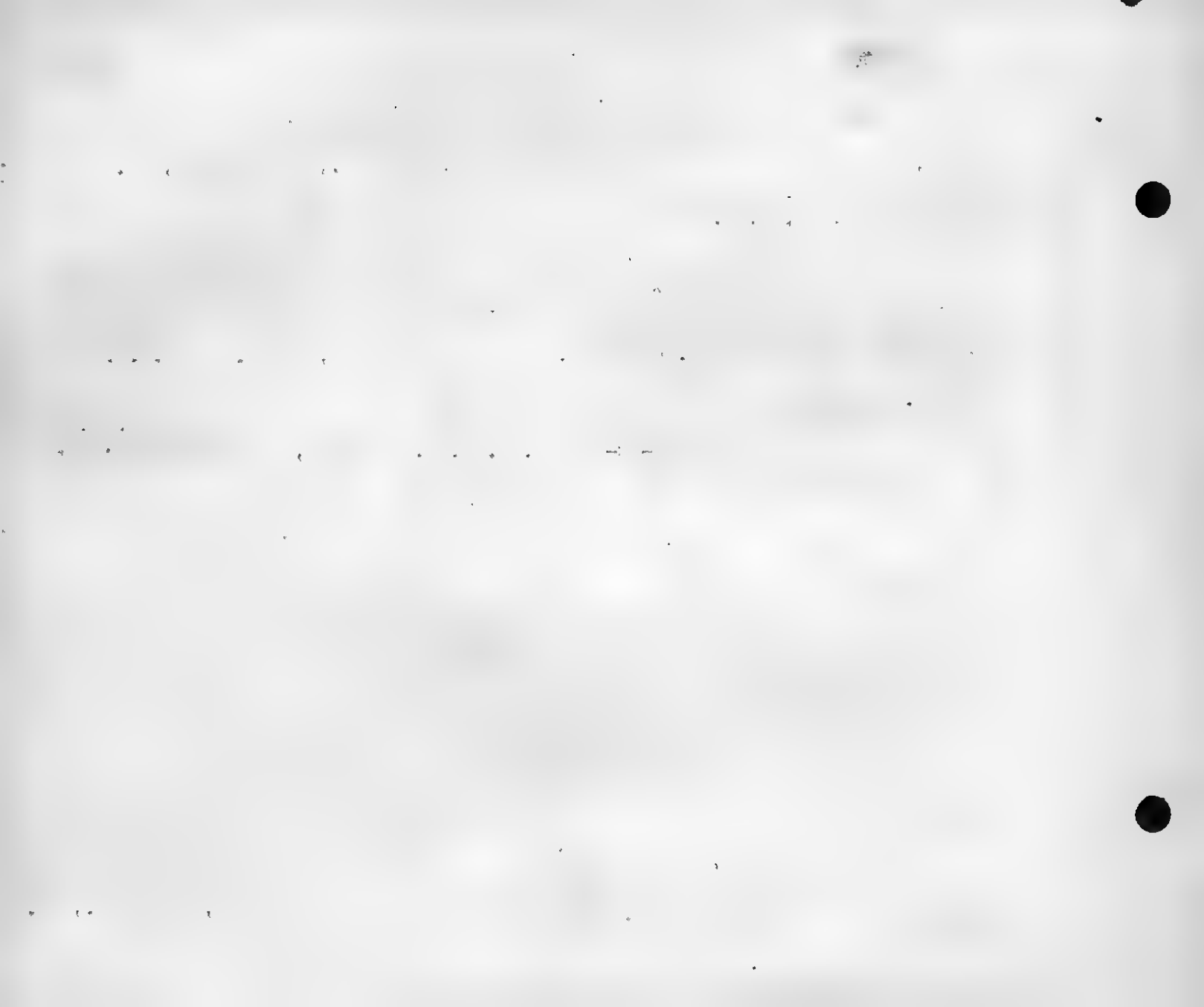
| | | | |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
CARROLL CO
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE
MARYLAND
b. COUNTY
CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WESTMINSTER | | c. LENGTH OF STAY IN Id
MINUETS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
CARROLL CO. GEN. HOSPITAL | | d. STREET ADDRESS
DEER PARK ROAD | |
| 3. NAME OF DECEASED
(Type or print)
GLADYS B. SLASMAN | | 4. DATE OF DEATH
Month 10 - Day 9 - Year 1967 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
DEC 5, 1914 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CONTROL SUPPLY | | 10b. KIND OF BUSINESS OR INDUSTRY
HOSPITAL | 9. AGE (In years last birthday)
52 yrs. |
| 11. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
PURCELL CARRICK | | 14. MOTHER'S MAIDEN NAME
GERTRUDE ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes give war or dates of service)
212-52-9511 | | 16. SOCIAL SECURITY NO.
212-52-9511 | |
| 17. INFORMANT
MR. J. HOWARD SLASMAN | | Address
FINKSBURG, RT#2 MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture Base Skull
DUE TO (b) Other Multiple Fractures
DUE TO (c) Other Multiple Fractures
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | INTERVAL BETWEEN ONSET AND DEATH
1 hr 25 min |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
car Ran off Road struck a Tree | |
| 20c. TIME OF INJURY Month Day Year
6:55 a.m. 10-9-67 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)
Carroll (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
W. J. Speicher | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
1355 Main St
Address (Street, city, county, state) | |
| 22. DATE SIGNED
10-9-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
10/12/67 | 23c. NAME OF CEMETERY OR CREMATORY
PROVIDENCE CEM. MD. | 23d. LOCATION (City or Town) (County) (State)
Westminster Carroll |
| 24. FUNERAL DIRECTOR
J. S. Myers, Jr. Westminster, Md. 21157 | | 25a. REC'D BY REGISTRAR
DATE OCT 11 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13735
13735
13735

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Pennsylvania b. COUNTY Adams | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural, Westminster | | | | c. LENGTH OF STAY IN 1b
4 1/2 Months | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Meadow View Convalescent Home Westminster, Md., R. D. 1 | | | | d. STREET ADDRESS
40 Lumber St., Littlestown, Pa. | | | |
| 3. NAME OF DECEASED (Type or print)
First Effie Middle Blanche Last Smith | | | | 4. DATE OF DEATH
Month October Day 3 Year 1967 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12/2/1891 | |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | 10. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife & Housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Her own home. | | 11. BIRTHPLACE (County & State, or foreign country)
Adams County, Penna. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
John J. Sanders | | | |
| 14. MOTHER'S MAIDEN NAME
Annie Watson | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
166-12-4295 | | | | 17. INFIRMANT
Mrs. P. K. Hymiller, | | | |
| Address 314 S. Queen St., Littlestown, Pa. | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
4700
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardio-Vascular Disease
DUE TO (c) 15 YRS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that (I) (this hospital) attended the deceased from JUNE 21, 1957 to OCT. 3, 1967 , that (I) (we) last saw the deceased alive on SEPT. 18, 1967 , and that death occurred at 5:40 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
L. L. Potter M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
OCT 4, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
L. L. POTTER M.D. | | | | 22d. ADDRESS
LITTLESTOWN, PA. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/6/67 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Aloysius Cemetery | | 23d. LOCATION (City, town or county) (State)
Littlestown, Adams Co., Pa. | |
| 24. FUNERAL DIRECTOR
Richard A. Little, Littlestown, PA. | | | | 25a. REC'D BY REGISTRAR
OCT 6 1967 | | | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |



13736

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13739

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
<u>Westminster</u> | | c. LENGTH OF STAY IN ^{1b}
<u>8 Days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Carroll County General Hospital</u> | | d. STREET ADDRESS
<u>111 Summit, Ave</u> | |
| 3 NAME OF DECEASED
(Type or print) <u>BLANCHE C. SNYDER</u> | | 4 DATE OF DEATH
Month <u>10</u> - Day <u>27</u> Year <u>1967</u> | |
| 5 SEX
<u>Female</u> | 6 COLOR OR RACE
<u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
<u>Dec. 18, 1902</u> |
| 9 AGE (in years last birthday)
<u>64</u> yrs | | 10 UNDER 1 YEAR
Months <u>10</u> Days <u>27</u> Hours <u>19</u> Min <u>67</u> | |
| 11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House-wife</u> | | 12 KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | |
| 13 FATHER'S NAME
<u>John C. Cook</u> | | 14 MOTHER'S MAIDEN NAME
<u>Mary B. Thurston</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16 SOCIAL SECURITY NO.
<u>217-12-1061</u> | |
| 17 INFORMANT
<u>Varnan A. Snyder</u> | | Address <u>111 Summit, Ave.</u>
<u>Hampstead, Md. 21074</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Pulmonary Embolism Bilateral (acute)</u>
DUE TO <u>Fractured Right Pelvis open Reduct</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Immobilization</u>
(c) <u>10-5-67</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>10-5-67</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS
PRIMARILY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
<u>Fell down steps at home landed on back</u> | |
| 20c. TIME OF INJURY Month, Day, Year
<u>1:30 p.m. 10-2-1967</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | 20f. (City or town) (County) (State)
<u>Hampstead Carroll Md.</u> |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion on death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>W. Glenn Speicher</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>John E. Soff</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 23b. DATE THEREOF
<u>10/31/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Wesley Cemetery</u> | | 23d. LOCATION (City or town) (County) (State)
<u>Hampstead Carroll Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>John E. Soff</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | 22. DATE SIGNED
<u>10-27-67</u> | |
| DATE
<u>OCT 31 1967</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13737

1357 (40)

| | | | |
|--|---|---|---|
| 1 PLACE OF DEATH
a. COUNTY
CARROLL | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c LENGTH OF STAY IN 1b
4 days | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | e STREET ADDRESS
3518 Ingleside Ave. | |
| 3 NAME OF DECEASED
(Type or print)
MOLLY ANN SOLOWESZYK | | 4 DATE OF DEATH
Month 10 Day 26 Year 19 67 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-18-14 |
| 9 AGE (In years last birthday)
53 yrs | | 10 IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | |
| 11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 12 KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13 BIRTHPLACE (County & State, or foreign country)
Poland | | 14 CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 15 FATHER'S NAME
DAVID REICHENBERG | | 16 MOTHER'S MAIDEN NAME
ANNA RAPPAPORT | |
| 17 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no | | 18 SOCIAL SECURITY NO.
unknown | |
| 19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Portal Cirrhosis
5 EIU
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) _____
(c) _____ | | 20 INTERVAL BETWEEN ONSET AND DEATH
unknown | |
| 21 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | 22 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 23 ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 24 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) | |
| 25 TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 26 INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 27 PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 28 (City or town) (County) (State) |
| 29 I certify that (I) (this hospital) attended the deceased from 10-24 , 19 67 , to 10-26 , 19 67 that (I) (we) last saw the deceased alive on 10-26 , 19 67 , and that death occurred at 10:18 PM , from causes and on the date stated above | | | |
| 30 SIGNATURE
D'Alfredo M. Labrit | | 31 ATTENDING PHYSICIAN
M.O. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 32 PHYSICIAN'S NAME (Type)
D'Alfredo M. Labrit | | 33 ADDRESS
Springfield State Hospital | |
| 34 BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 35 DATE THEREOF
10-29-67 | 36 NAME OF CEMETERY OR CREMATORY
CHOFETZ HEBREW MT. CARMEL CHAM | 37 LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 38 FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD | | 39 REC'D BY REGISTRAR
NOV 6 1967 | |
| 40 REGISTRAR'S SIGNATURE
Charles Judge | | 41 REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13738

CERTIFICATE OF DEATH

13741

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|--|--|--|--|
| 1 PLACE OF DEATH
a. COUNTY CARROLL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
42 yr 5 mo 15 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
da. unknown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
----- | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First WILBUR Middle BRUCE Last SPEAKE | | | | 4. DATE OF DEATH
Month 10/ Day 25 Year 19 67 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/2/98 | | 9. AGE (In years last birthday)
69 yrs | IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (County & State, or foreign country)
Frederick County | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Calvin I. Speake | | | | 14. MOTHER'S MAIDEN NAME
Emma Jane Derr | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Springfield State Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
4221
DUE TO (b) Uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Generalized arteriosclerosis, Art. cardiovascular disease yrs. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CBS assoc. with convulsive disorder without qualifying phrase | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/10/25 , 19 67 , to 10/25/ , 19 67 , that (I) (we) last saw the deceased alive on 10/25/ , 19 67 , and that death occurred at 7:35 AM , from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE
Suha Ozgun. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10/25/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Suha Ozgun, M. D. | | | | 22d. ADDRESS
Springfield State Hospital | | | |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify)
Burial | | 23b. DATE THEREOF
10/28/67 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Johns Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Greagerstown, Ind., Ind. | |
| 24. FUNERAL DIRECTOR
W. C. Barton | | | | 25a. REC'D BY REGISTRAR
W. C. Barton | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

DATE: 30 1967

100



100



100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

137413

1
FOR STATE
HEALTH DEPT.

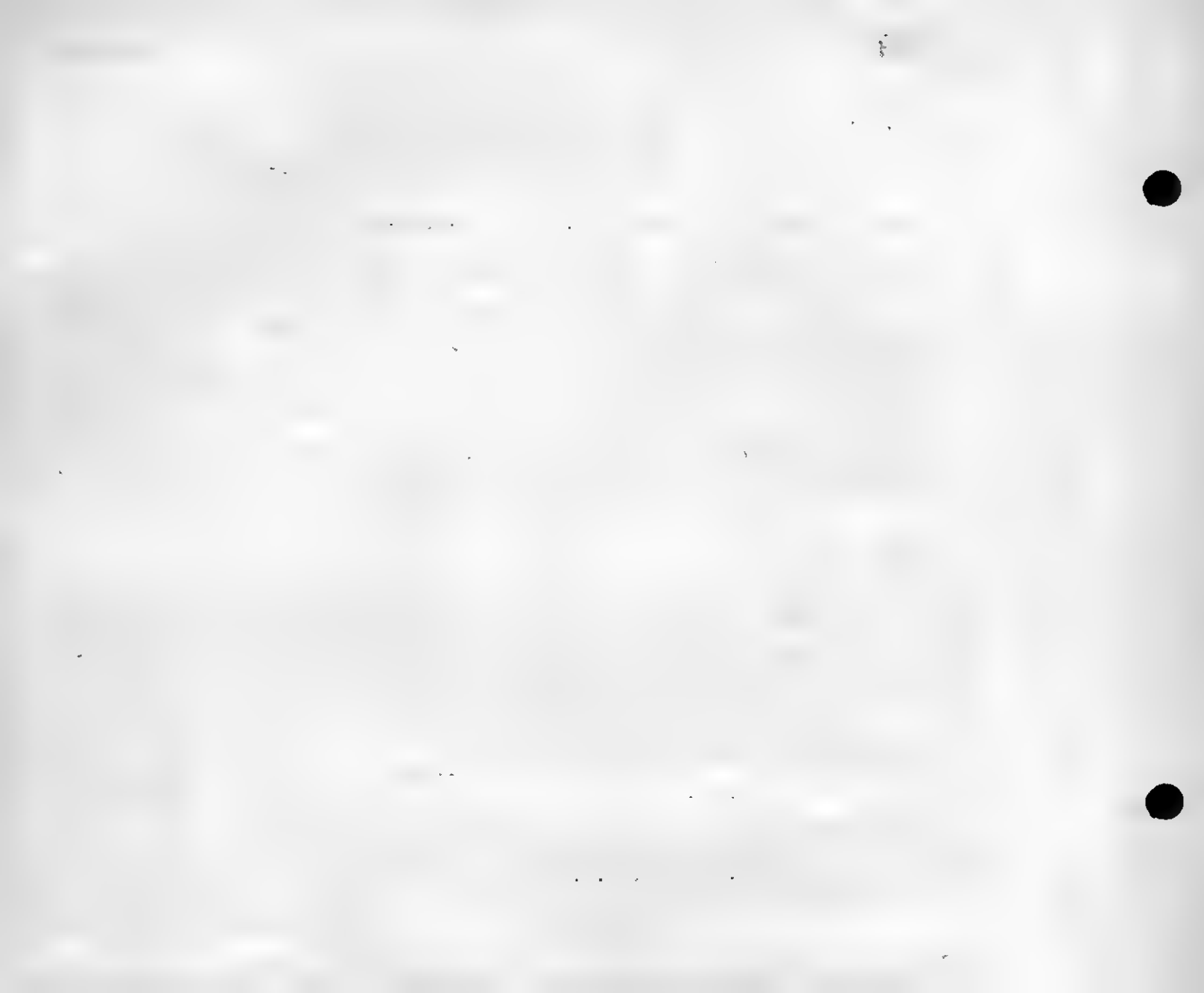
M

13739

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY in b
Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Railroad Yard, Sykesville, Md. | | | | d. STREET ADDRESS
Sykesville, Maryland | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
BENJAMIN PEYTON SULLIVAN | | | | 4. DATE OF DEATH
Month Day Year
October 29 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 30, 1917 | 9. AGE (in years last birthday)
49 yrs | F UNDER 1 YEAR
Months Days Hours Min | | F UNDER 24 HRS
Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY
Food | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
EMMA CLARK | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes U.W. II | | 16. SOCIAL SECURITY NO
? | | 17. INFORMANT
Mrs. Helen Duval - Sykesville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) 4221
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Edward F. Wilson M.D. | | | | 22. DATE SIGNED October 30, 1967 | | | |
| EXAMINER'S NAME (Type) Edward F. Wilson, M.D. | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) Baltimore Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
11-1-67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
Harry W. Haight Sykesville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE NOV 2 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. Page 2 of 3 should be retained by the funeral director. Page 3 of 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-------------------------------|--|--|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 13741 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL CO.</u> <u>MARYLAND</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> | | | | | | c. LENGTH OF STAY IN 1b <u>3 WEEKS +</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPITAL (FRIZELLSBURG)</u> | | | | | | e. STREET ADDRESS <u>WESTMINSTER, RT# 7</u> | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last | | | | | | 4. DATE OF DEATH Month Day Year | | | | | |
| <u>WINFIELD SCOTT SULLIVAN</u> | | | | | | <u>OCT 24 1967</u> | | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>OCT. 8, 1886</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months Days | |
| | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | IF UNDER 24 MRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR, FLOUR MILL AND DAIRY</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO.</u> | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>PLEASANT VALLEY MD.</u> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>ISAAC N. SULLIVAN</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>MARY JANE TOWNSEND</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | | | 16. SOCIAL SECURITY NO. <u>212-01-874</u> | | | | | |
| 17. INFORMANT <u>MRS W. SCOTT SULLIVAN, WESTMINSTER, MD.</u> | | | | | | Address <u>RT# 7</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas</u>
DUE TO (b) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> 19 <u>62</u> , to <u>10/24</u>, 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> .. 19 <u>67</u> ., and that death occurred at <u>8:15</u> A.M., from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>John S. Harshey</u> M.D. | | | | | | 22b. DATE SIGNED <u>10/24/67</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY M.D.</u> | | | | | | 22d. ADDRESS <u>8 Anchor St. Westminster, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | | 23b. DATE THEREOF <u>10/27/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEMETERY</u> | | 23d. LOCATION (City, town or county) (State) <u>WESTMINSTER MD.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Thompson, Jr., Westminster, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE | | DATE <u>OCT 31 1967</u> | |



13741

CERTIFICATE OF DEATH

137415

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|---|
| 1 PLACE OF DEATH
a. COUNTY <u>Carroll</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>
c. LENGTH OF STAY IN 1b <u>3m. 11d.</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Balt.</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 30</u>
d. STREET ADDRESS <u>3808 old York Road</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print)
First <u>Wilson</u> Middle <u>Bowman</u> Last <u>Swain</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>8</u> Year <u>1967</u> | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-9-92</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>344-09-1224</u> | 9 AGE (In years last birthday) <u>74</u> yrs |
| 11 BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13 FATHER'S NAME <u>Nelson Swain</u> | | 14 MOTHER'S MAIDEN NAME <u>?</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16 SOCIAL SECURITY NO <u>344-09-1224</u> | |
| 17 INFORMANT <u>Springfield Hospital records - Sykesville</u> | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
471A DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> o.m. p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6-27-</u> , 19 <u>67</u> , to <u>10-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>10</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Mario E. Comas</u> | | 22b. DATE SIGNED <u>10/8/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>MARIO E. COMAS M.D.</u> | | 22d. ADDRESS <u>1302 KENSEL CT. Baltimore</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>10/10/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u> | 23d. LOCATION (City or town) (County) (State) <u>Freeland Balto. Md.</u> |
| 24. FUNERAL DIRECTOR <u>David Hartenstein</u> | | 25a. REC'D BY REGISTRAR <u>NEW FREEDOM, Pa.</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jager</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

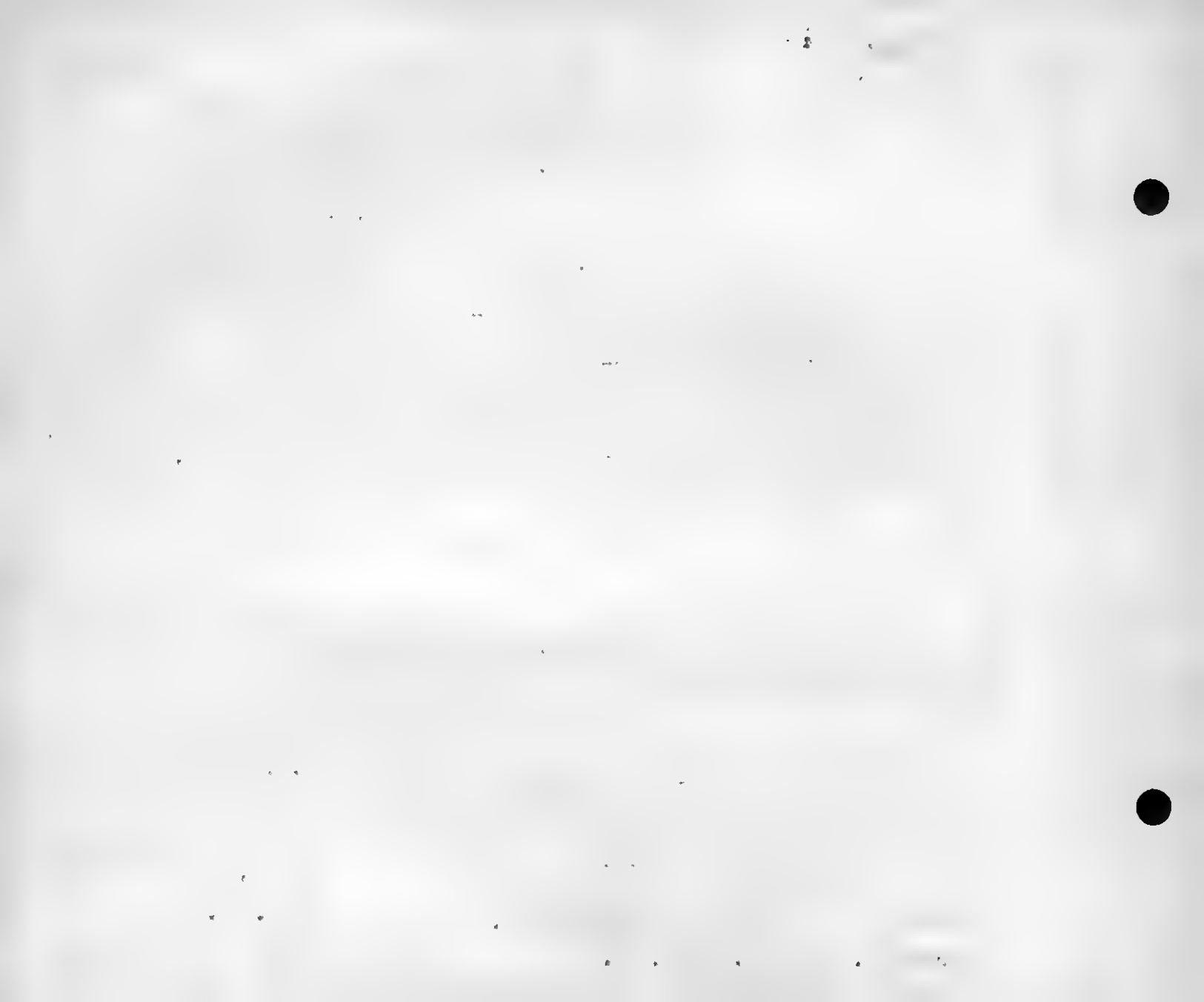
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13742

13746

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
14yrs.6mo.9days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | d. STREET ADDRESS
1411 Poplar Grove | |
| 3. NAME OF DECEASED (Type or print)
First MINNIE Middle R. Last TAYLOR | | 4. DATE OF DEATH
Month October Day 25 , Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-16-84 |
| 9. AGE (In years last birthday)
83 yrs | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
School teacher | | 10b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Watson | | 14. MOTHER'S MAIDEN NAME
Martha R. Coleman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
N | | 16. SOCIAL SECURITY NO
218-01-8855 | |
| 17. INFORMANT
Records | | Address Sykesville, Springfield State Hospital, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Pneumonia
DUE TO (b) Acute congestive heart failure.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) --- | | | INTERVAL BETWEEN ONSET AND DEATH
12hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Involuntional psychotic reaction. | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4-16, 1953 to 10-25, 1967 , that (I) (we) lost saw the deceased alive on 10-25, 1967 , and that death occurred at 5:50 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Irfan Esendal M.D. | | 22b. DATE SIGNED
10-25-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Irfan, Esendal, M.D. | | 22d. ADDRESS
Springfield State Hospital Sykesville, Maryland | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10/28/67 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | 23d. LOCATION (City or Town) (County) (State)
Balto. Md. |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 30 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



13743

CERTIFICATE OF DEATH

137417

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
CARROLL
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE
MARYLAND
b. COUNTY
CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FINKSBURG RT#2 | | c. LENGTH OF STAY IN 1b
1 YEAR 1/2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
LAWNDALE ROAD | | d. STREET ADDRESS
LAWNDALE ROAD | |
| 3. NAME OF DECEASED
(Type or print)
Lilly MAY TROUT | | 4. DATE OF DEATH
Month OCT. Day 10 Year 1967 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
SEPT 6 1894 |
| 9. AGE (n years lost birthday)
73 yrs | | 10. IF UNDER 1 YEAR
Months 1 Days 10 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE-WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
FREDERICK CO. MD | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN BYARD | | 14. MOTHER'S MAIDEN NAME
JOSEPHINE WETZEL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
213-26-0574 | |
| 17. INFORMANT
MR. JAMES A. TROUT, FINKSBURG, RT#2 MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Oedema
DUE TO (b) Chronic Myocarditis
DUE TO (c) Arterio-sclerosis - C-V. Disease | | | INTERVAL BETWEEN ONSET AND DEATH
1 hr.
10 yr.
10 yr. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3-30 , 19 59 , to 10-10 , 19 67 , that (II) (we) last saw the deceased alive on 10-10 19 67 , and that death occurred at 10:40 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
M.C. Porterfield | | 22b. DATE SIGNED
10-11-67 | |
| 22c. PHYSICIAN'S NAME (Type)
M.C. Porterfield | | 22d. ADDRESS
Hampstead, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
OCT. 13, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
EVERGREEN MEM. GARDEN | 23d. LOCATION (City or Town) (County) (State)
FINKSBURG, CARROLL CO. |
| 24. FUNERAL DIRECTOR
J.S. Myers, Jr., Westminster, Md. | | 25a. REC'D BY REGISTRAR
OCT 16 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | MD | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

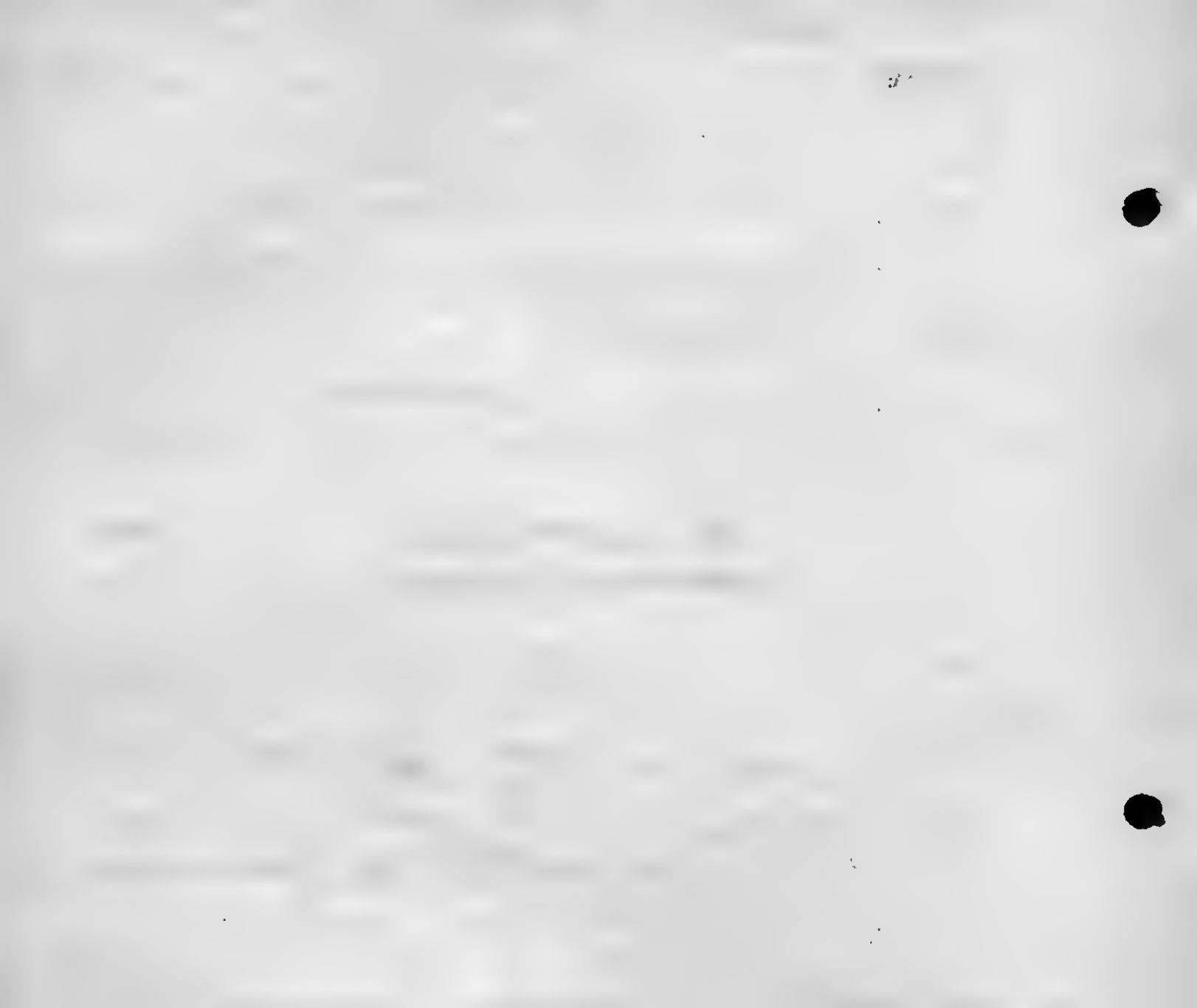
CERTIFICATE OF DEATH

13748

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY in b. MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll County General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 4132 Parkside Drive
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) LULA M. UNGER | | 4. DATE OF DEATH
Month October Day 24 Year 19 67 | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 3, 1908 | |
| 9. AGE (In years last birthday) 59 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Beck | | 14. MOTHER'S MAIDEN NAME Augusta Bettien | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Elliott F. W. Unger, 4132 Parkside Drive | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last Atherosclerosis Heart Disease
DUE TO 3 days
DUE TO 3 years | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital), attended the deceased from 10/24, 1967, to 10/24, 1967, that (I) (we) last saw the deceased alive on 10/24, 1967, and that death occurred at 9:50 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John S. Harshey M.D. | | 22b. DATE SIGNED 10/24/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D. | | 22d. ADDRESS 8 Ancher St Westminster, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/28/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION (City, town or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road. | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

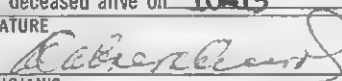
13749

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Manchester</u> | | c. LENGTH OF STAY IN 16
<u>3 months</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Long View Nursing Home Inc</u> | | d. STREET ADDRESS
<u>Route 2</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Grace</u> Middle <u>L</u> Last <u>Warehime</u> | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>12</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan 22, 1873</u> |
| 9. AGE (in years last birthday)
<u>94</u> yrs | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Carroll County, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Benjamin Byers</u> | | 14. MOTHER'S MAIDEN NAME
<u>Caroline Stocksdate</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>216-46-4665</u> | |
| 17. INFORMANT
<u>June Warehime, Box 169 Owings Mills, Md.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u>
DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 YRS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>7/19</u> , 19 <u>67</u> , to <u>10/12</u> , 19 <u>67</u> , that <u>(1)</u> (we) lost the deceased alive on <u>10/10</u> , 19 <u>67</u> , and that death occurred at <u>7:45 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W. H. Foard</u> | | 22b. DATE SIGNED
<u>10/12/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W. H. Foard M.D.</u> | | 22d. ADDRESS
<u>Manchester, Md 21102</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>10/14/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>MEADOW BRANCH CEMETERY Westminster, Md.</u> | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR
<u>J. S. Myers, Jr. Westminster, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>DATE OCT 16 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|---|--|--|--|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville, Md.
c. LENGTH OF STAY IN 1b 2 Yrs. 5 Mo 14
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Garrett
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Lonaconing, Md.
d. STREET ADDRESS Avilton area
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print) Eliza Katherine (Evans) Warnick
First Middle Last
5. SEX F
6. COLOR OR RACE white
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 4. DATE OF DEATH
Month 10-15 Day 19 Year 1967
8. DATE OF BIRTH 4-9-91
9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months 7 Days 15 Hours 15 Min. IF UNDER 24 HRS. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Cotton Mill | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME
Peter Abraham Evans | | | | | 14. MOTHER'S MAIDEN NAME
Minty Schell | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. 220-10-2932 | | 17. INFORMANT Address Springfield Hospital Records Sykesville | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
DUE TO Coronary artery disease with old myocardial infarct.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) myocardial infarct.
DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Weeks
Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
CBS Assoc. With Cerebral Art. with behavioral reaction | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that th (this hospital) attended the deceased from 4-16 , 19 65 , to 10-15 , 19 67 , that th (we) last saw the deceased alive on 10-15 , 19 67 , and that death occurred at 11a M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
 | | | | | | | | 22b. DATE SIGNED
10-16-67 | |
| 22c. PHYSICIAN'S NAME (Type) Orlando Cabrera, M. D. | | | | | 22d. ADDRESS Springfield State Hospital Sykesville, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 10/19/67 | | 23c. NAME OF CEMETERY OR CREMATORY Nethken Hill Cemetery | | 23d. LOCATION (City, town or county) (State) Elk Garden, Mineral Co. W.V. | | |
| 24. FUNERAL DIRECTOR
Blaine, W. Va.
P.O. Kitzmiller, Md. | | | | | 25a. REC'D BY REGISTRAR Charles Judge
25b. REGISTRAR'S SIGNATURE
DATE OCT 19 1967 | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13747

| | | | |
|--|--------------------------|---|------------------------------|
| 1 PLACE OF DEATH
a COUNTY
Carroll
MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE
Maryland
b COUNTY
Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
89yrs. 6mos. 3wks. Baltimore | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | d. STREET ADDRESS
1410 Morling Ave. | |
| 3 NAME OF DECEASED
(Type or print)
First Middle Last
GEORGE E. WEISE | | 4 DATE OF DEATH
Month Day Year
OCTOBER 22 19 67 | |
| 5 SEX
Male | 6 COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-22-04 |
| 9. AGE (in years last birthday)
63 yrs | | IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Christian E. Weise | | 14. MOTHER'S MAIDEN NAME
Cora Bald | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
579-01-0972 | |
| 17 INFORMANT
Address
Records, Springfield State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Recent myocardial infarction
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Coronary artery thrombosis
DUE TO
(c) Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH
Weeks
Weeks
Days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Manic depressive reaction, other | | 19 WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-19-28, 19, to 10-22-67, 19, that (I) (we) last saw the deceased alive on 10-22-67, 19, and that death occurred at 7:40 P.M. from causes and on the date stated above. | | | |
| 22a SIGNATURE
Octavio A. Ruiz, M.D. | | 22b DATE SIGNED
10-23-67 | |
| 22c PHYSICIAN'S NAME (Type)
Octavio A. Ruiz, M. D. | | 22d ADDRESS
Springfield State Hospital
Sykesville, Maryland | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b DATE THEREOF
10-25-67 | |
| 23c NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d LOCATION (City or Town) (County) (State)
BALTIMORE, MD | |
| 24. FUNERAL DIRECTOR
ADDRESS
BURGEE FUNERAL HOME 3631 FALL RIVER RD | | 25a REC'D BY REGISTRAR
DATE OCT 25 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13743

13752

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Md. | | b. COUNTY
Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hampstead | | c. LENGTH OF STAY IN TB | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hampstead | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
119 N. Main Street | | d. STREET ADDRESS
119 N. Main Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
THOMAS HARRISON WISNER | | 4. DATE OF DEATH
Month 10 - Day 23 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 31, 1914 | 9. AGE (In years last birthday)
53 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
Balto. Co. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
William H. Wisner | | 14. MOTHER'S MAIDEN NAME
Kathryn Hedrick | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WWII | | 16. SOCIAL SECURITY NO.
212-16-0996 | | 17. INFORMANT
Mrs. Edna E. Wisner Address Hampstead, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound, heart
976X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO (b) Self inflicted (25 cal.)
(c) | | 19. INTERVAL BETWEEN ONSET AND DEATH
Sudden | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
apparently shot self in heart | | | |
| 20c. TIME OF INJURY Month, Day, Year
3:00 p.m. 10/23 1967 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | |
| 20f. (City or town)
Hampstead | | 20g. (County)
Carroll | | 20h. (State)
Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
10-23-67 | |
| ACTUAL SIGNATURE
W. E. E. Speicher | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
W. E. E. Speicher | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 26, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | |
| 23d. LOCATION (City or Town)
Baltimore | | 23e. (County)
Md. | | 23f. (State) | |
| 24. FUNERAL DIRECTOR
Tipton-Eline Funeral Home | | ADDRESS
Hampstead, Md. | | 25a. REC'D BY REGISTRAR
Oct 27 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13749

CERTIFICATE OF DEATH

13753

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville | | c. LENGTH OF STAY IN 1b
2y. 4m. 3d. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Michael NMN Yatchyshyn | | 4. DATE OF DEATH
Month 10 Day 28 Year 1967 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/11/82?-84? |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
82?84? yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
Ukraine | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
??Mitro Yatchyshyn (181-28-1617 A) | | 14. MOTHER'S MAIDEN NAME
?? Catherine Steinchak | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Springfield Hospital records, Sykesville | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Branchopneumonia
DUE TO (b) 491X
DUE TO (c) 491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic brain syndrome associated with cerebral arteriosclerosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
With psychotic reaction. | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from 6/25/65 , 19 65 , to 10/28 , 1967, that (2) (we) last saw the deceased alive on 10/28 , 19 67 , and that death occurred at 7:30PM , from causes and on the date stated above | | | |
| 22a. SIGNATURE
Ramon P. Lopez | | 22b. DATE SIGNED
10/28/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Ramon P. Lopez | | 22d. ADDRESS
Springfield State Hospital Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
10-31-67 | 23c. NAME OF CEMETERY OR CREMATORY
Monogahela Mem. Park | 23d. LOCATION (City or Town) (County) (State)
DONORA PA. |
| 24. FUNERAL DIRECTOR
Harry W. Haight Sykesville, Md. | | 25a. REC'D BY REGISTRAR
OCT 31 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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UNITED STATES

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